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The Iowa Administrative Code (IAC) Supplement is published biweekly pursuant to Iowa Code sections 2B.5A and 17A.6. The Supplement is a compilation of updated Iowa Administrative Code chapters that reflect rule changes which have been adopted by agencies and filed with the Administrative Rules Coordinator as provided in Iowa Code sections 7.17, 17A.4, and 17A.5 and published in the Iowa Administrative Bulletin bearing the same publication date as the one for this Supplement. To determine the specific changes to the rules, refer to the Iowa Administrative Bulletin. To maintain a loose-leaf set of the IAC, insert the chapters according to the instructions included in the Supplement.

In addition to the rule changes adopted by agencies, the chapters may reflect objection to a rule or a portion of a rule filed by the Administrative Rules Review Committee (ARRC), the Governor, or the Attorney General pursuant to Iowa Code section 17A.4(6); an effective date delay or suspension imposed by the ARRC pursuant to section 17A.8(9) or 17A.8(10); rescission of a rule by the Governor pursuant to section 17A.4(8); nullification of a rule by the General Assembly pursuant to Article III, section 40, of the Constitution of the State of Iowa; other action relating to rules enacted by the General Assembly; updated chapters for the Uniform Rules on Agency Procedure; or an editorial change to a rule by the Administrative Code Editor pursuant to Iowa Code section 2B.13(2).

INSTRUCTIONS

FOR UPDATING THE

IOWA ADMINISTRATIVE CODE

Agency names and numbers in bold below correspond to chapters of the Iowa Administrative Code (IAC) with amended content that are included in this Supplement. Such chapters can be replaced. Also included are new chapters published in the IAC for the first time.

Editor's telephone 515.281.3355

Administrative Rules Coordinator[7]

Replace Chapter 2506

Insurance Division[191]

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Human Services Department[441]

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Workforce Development Department[871]

Replace Analysis

Replace Chapters 79 to 2506

CHAPTER 2506
CONTESTED CASES

Chapter rescission date pursuant to Iowa Code section 17A.7: 5/6/31

7—2506.1(17A) Scope and applicability. This chapter applies to contested case proceedings conducted by the agency, including vendor appeals.

[ARC 0190D, IAB 4/1/26, effective 5/6/26]

7—2506.2(17A) Definitions. Except where otherwise specifically defined by law:

“*Contested case*” means a proceeding defined by Iowa Code section 17A.2(5) and includes any matter defined as a no factual dispute contested case under Iowa Code section 17A.10A.

“*Issuance*” means the date of mailing or electronic filing of a decision or order or date of delivery if service is by other means unless another date is specified in the order.

“*Party*” means each person named or admitted as a party or properly seeking and entitled as of right to be admitted as a party.

“*Presiding officer*” means the person designated pursuant to Iowa Code section 17A.11.

“*Proposed decision*” means the presiding officer’s recommended findings of fact, conclusions of law, decision, and order in a contested case in which the agency did not preside.

[ARC 0190D, IAB 4/1/26, effective 5/6/26]

7—2506.3(17A) Time obligations.

2506.3(1) Time is computed as provided in Iowa Code section 4.1(34).

2506.3(2) For good cause, the presiding officer may extend or shorten the time to take any action, except when prohibited by statute. Except for good cause stated in the record, before extending or shortening the time to take any action, the presiding officer will afford all parties an opportunity to be heard or to file written arguments.

[ARC 0190D, IAB 4/1/26, effective 5/6/26]

7—2506.4(17A) Electronic requests for contested case proceeding.

2506.4(1) A person entitled to a contested case proceeding shall, whenever possible, electronically file written request for such a proceeding within the time specified by the governing rules or statutes or, if no rule or statute sets such a time, the time set by the agency.

2506.4(2) The request for a contested case proceeding must state the name, email, and address of the requester and identify the specific agency action disputed. Where the requester is represented by an attorney, the request must identify the law or precedent requiring or authorizing the holding of a contested case proceeding and include a short and plain statement of the issues of material fact in dispute.

[ARC 0190D, IAB 4/1/26, effective 5/6/26]

7—2506.5(17A) Notice of hearing.

2506.5(1) Delivery. The agency will deliver notice of a hearing. Delivery shall, whenever possible, be effectuated through electronic means. Otherwise, delivery can be effectuated by:

- a. Personal service as provided in the Iowa Rules of Civil Procedure; or
- b. Certified mail, return receipt requested; or
- c. First-class mail; or
- d. Publication as provided in the Iowa Rules of Civil Procedure.

2506.5(2) Contents. The notice of hearing must state:

- a. The time, place, and nature of the hearing;
- b. The legal authority and jurisdiction under which the hearing is to be held;
- c. The particular sections of the statutes and rules involved;

- d.* Briefly and plainly, the matters asserted. If a party cannot state the matters in detail when the notice is served, the party may limit the initial notice to a statement of the issues involved but must supplement it with a more definite and detailed statement if requested by another party;
- e.* All parties, including the name, address, and telephone number of the person who will advocate for each party;
- f.* The procedural rules governing conduct of the contested case proceeding;
- g.* The procedural rules governing informal settlement, which can occur at any time;
- h.* The identity of the presiding officer, if known, or, if not, a description of who will serve as presiding officer; and
- i.* The deadline to request under Iowa Code section 17A.11 and rule 7—2506.6(17A) that the presiding officer be an administrative law judge.

[ARC 0190D, IAB 4/1/26, effective 5/6/26]

7—2506.6(17A) Presiding officer.

2506.6(1) Any party that wants an administrative law judge employed by the department of inspections, appeals, and licensing to serve as the presiding officer must file a request. The deadline for that request is 20 days after service of a notice of hearing that identifies someone other than an administrative law judge as the presiding officer.

2506.6(2) The agency or its designee may deny the request for any of the reasons set forth in Iowa Code section 17A.11(1)“a.”

2506.6(3) The agency or its designee is obligated to issue a written ruling specifying the grounds for its decision within 20 days after a request for an administrative law judge is filed.

2506.6(4) Except as otherwise prohibited by law, all final rulings by an administrative law judge acting as presiding officer are subject to appeal to the agency. A party is obligated to seek any available appeal to the agency in order to exhaust available administrative remedies.

2506.6(5) Except as otherwise set forth in law, heads of agencies and members of governmental agencies, when reviewing a proposed decision upon appeal to the agency, have the powers and duties of this chapter applicable to presiding officers.

[ARC 0190D, IAB 4/1/26, effective 5/6/26]

7—2506.7(17A) Waiver of procedures. Unless otherwise prohibited by law, the parties in a contested case proceeding may waive any portion of this chapter. However, the agency in its discretion may refuse to give effect to such a waiver when it deems the waiver to be inconsistent with the public interest.

[ARC 0190D, IAB 4/1/26, effective 5/6/26]

7—2506.8(17A) Telephone proceedings. The presiding officer may resolve preliminary procedural motions by telephone or videoconference in which all parties have an opportunity to participate. Other telephone proceedings may be held with the consent of all parties. The presiding officer will determine the location of the parties and witnesses for telephone hearings. The convenience of the witnesses or parties, as well as the nature of the case, must be considered when a location is chosen.

[ARC 0190D, IAB 4/1/26, effective 5/6/26]

7—2506.9(17A) Disqualification.

2506.9(1) A presiding officer or other person must withdraw from participation in the making of any proposed or final decision in a contested case if that person:

- a.* Has a personal bias or prejudice concerning a party or a representative of a party;
- b.* Has personally investigated, prosecuted, or advocated in connection with that case, the specific controversy underlying that case, another pending factually related contested case, or a pending factually related controversy that may culminate in a contested case involving the same parties;

c. Is subject to the authority, direction or discretion of any person who has personally investigated, prosecuted, or advocated in connection with that contested case, the specific controversy underlying that contested case, or a pending factually related contested case or controversy involving the same parties;

d. Has acted as counsel to any person who is a private party to that proceeding within the past two years;

e. Has a personal financial interest in the outcome of the case or any other significant personal interest that could be substantially affected by the outcome of the case;

f. Has a spouse or relative within the third degree of relationship who is:

- (1) A party to the case or an officer, director or trustee of a party;
- (2) An attorney in the case;
- (3) Known to have an interest that could be substantially affected by the outcome of the case; or
- (4) Likely to be a material witness in the case; or

g. Has any other legally sufficient cause to withdraw from participation in the decision making in that case.

2506.9(2) The term “personally investigated” means taking affirmative steps to interview witnesses directly or to obtain documents or other information directly. The term does not include general direction and supervision of assigned investigators, unsolicited receipt of information relayed to assigned investigators, review of another person’s investigative work product in the course of determining whether there is probable cause to initiate a proceeding, or exposure to factual information while performing other agency functions, including fact gathering for purposes other than investigation of the matter that culminates in a contested case. If the presiding officer in the case has received factual information relevant to the merits of a contested case before being assigned as the presiding officer, the presiding officer is obligated to disclose that information to the parties to the extent required by Iowa Code section 17A.17(3) and subrules 2506.9(3) and 2506.23(9).

2506.9(3) A party that believes a presiding officer is disqualified must file a motion supported by an affidavit in accordance with Iowa Code section 17A.17(7). The motion must be filed as soon as practicable after the reason alleged in the motion becomes known to the party.

a. If a party during the course of the hearing becomes aware of evidence of bias or other grounds for disqualification, the party may move for disqualification at that time but must establish the grounds introducing the evidence into the record.

b. If disqualification is required, the presiding officer or other person is obligated to withdraw. If withdrawal is not required, the presiding officer will enter an order to that effect. A party asserting disqualification may seek an interlocutory appeal under rule 7—2506.25(17A) and seek a stay under rule 7—2506.29(17A).

[ARC 0190D, IAB 4/1/26, effective 5/6/26]

7—2506.10(17A) Consolidation—severance.

2506.10(1) *Consolidation.* The presiding officer may consolidate matters at issue in two or more contested case proceedings if:

- a. The matters involve common parties or common questions of fact or law;
- b. Consolidation would expedite and simplify consideration of the issues involved; and
- c. Consolidation would not adversely affect the rights of any of the parties to those proceedings.

2506.10(2) *Severance.* The presiding officer may, for good cause shown, order any contested case or portion of a contested case severed.

[ARC 0190D, IAB 4/1/26, effective 5/6/26]

7—2506.11(17A) Pleadings.

2506.11(1) *Filing requirements.* Filing requirements may be imposed by rule, by the notice of hearing, or by order of the presiding officer.

2506.11(2) *Petition.*

a. Any necessary petition in a contested case proceeding will be filed within 20 days of delivery of the notice of hearing or subsequent order of the presiding officer unless otherwise ordered.

b. A petition will state in separately numbered paragraphs the following:

(1) The persons or entities on whose behalf the petition is filed;

(2) The particular provisions of statutes and rules involved;

(3) The relief demanded and the facts and law relied upon for such relief; and

(4) The name, address, email, and telephone number of the petitioner and the petitioner's attorney, if any.

2506.11(3) *Answer.* A party against whom a petition is filed must file an answer within 20 days of service of the petition unless otherwise ordered. A party may instead move to dismiss or apply for a more definite and detailed statement when appropriate.

a. An answer must state on whose behalf it is filed and specifically admit, deny, or otherwise answer all material allegations of the pleading to which it responds. It must state all facts deemed to show an affirmative defense and contain as many additional defenses as the pleader may claim.

b. An answer must state the name, address, email, and telephone number of the person filing the answer, the person or entity on whose behalf it is filed, and the attorney representing that person, if any.

c. Any allegation in the petition not denied in the answer is considered admitted. If a defense could have been raised in the answer but was not, the presiding officer may refuse to consider it if doing so would prejudice any party.

2506.11(4) *Amendment.* Any notice of hearing, petition, or other charging document may be amended before a responsive pleading has been filed. Amendments to pleadings after a responsive pleading has been filed and to an answer may be allowed with the consent of the other parties or in the discretion of the presiding officer who may impose terms or grant a continuance.

[ARC 0190D, IAB 4/1/26, effective 5/6/26]

7—2506.12(17A) Electronic service and filing of pleadings and other papers.

2506.12(1) *Filing and service electronically.* Every pleading, motion, document, or other paper that is filed or served shall be executed electronically whenever possible. Filing or service by a non-electronic method can only be upon a showing to the presiding officer of undue hardship to use email.

2506.12(2) *When service mandated.* Except where otherwise provided by law, every pleading, motion, document, or other paper filed in a contested case proceeding and every paper relating to discovery in such a proceeding must be served upon each of the parties of record to the proceeding, including the person designated as advocate or prosecutor for the state or the agency. Service must be at the same time as filing. Except for the original notice of hearing and an application for rehearing, as described in Iowa Code section 17A.16(2), the party filing a document is responsible for service on all parties.

2506.12(3) *Service—how made.* Service upon a party represented by an attorney will be made upon the attorney unless otherwise ordered. Service shall be made electronically or, to the extent permitted in subrule 2506.12(1), by mailing a hard copy to the person's last-known address. Service by mail is complete upon mailing, except where otherwise specifically provided by statute, rule, or order.

2506.12(4) *Filing—when mandated.* After the notice of hearing, all pleadings, motions, documents or other papers in a contested case proceeding must be filed with the agency at the agency's address or agency's email. All pleadings, motions, documents or other papers that need to be served upon a party must be filed with the agency at the same time they are served.

2506.12(5) *Filing—when made.* Except where otherwise provided by law, a document is deemed filed at the time it is submitted to the department of inspections, appeals, and licensing electronic filing system, submitted to a separate agency electronic filing system, delivered to the agency's address or agency's email, delivered to an established courier service for immediate delivery to that

office, or mailed by first-class mail or state interoffice mail to that office, so long as there is proof of mailing.

2506.12(6) *Copies by email.* Whenever possible, the parties shall provide opposing parties copies of all filings by email.

2506.12(7) *Proof of mailing.* In circumstances where non-electronic service is approved by the presiding officer, a proof of mailing is required, which includes either a legible United States Postal Service postmark on the envelope, a certificate of service, or a certification in substantially the following form:

I certify under penalty of perjury under the laws of Iowa that, on (date of mailing),
I mailed copies of (describe document) addressed to the agency at the agency's
address, and to the names and addresses of the parties listed below by depositing the
same in (method of delivery).

(Date) (Signature)

[ARC 0190D, IAB 4/1/26, effective 5/6/26]

7—2506.13(17A) Discovery.

2506.13(1) Discovery procedures applicable in civil actions are applicable in contested cases. Unless lengthened or shortened by these rules or by order of the presiding officer, time periods for compliance with discovery are as set forth in the Iowa Rules of Civil Procedure. No new discovery under Iowa Rules of Civil Procedure 1.509, 1.510, and 1.512 may be served within 40 days of the scheduled hearing. All discovery must be completed no later than ten days before the scheduled hearing.

2506.13(2) Parties must not file motions relating to discovery unless they have first in good faith attempted to resolve the issue with the opposing party. A party filing a discovery motion must certify, under penalty of perjury, that it has made that good-faith attempt. Lack of such a certificate constitutes sufficient grounds for denying the motion.

2506.13(3) Unless shortened in accordance with subrule 2506.13(1), a discovery motion is ripe for ruling by the presiding officer ten days after the motion is filed. Opposing parties may file a response within that time. The presiding officer may order argument or rule on the parties' filings.

2506.13(4) Evidence obtained in discovery may be used in the contested case proceeding if that evidence would otherwise be admissible in that proceeding.

[ARC 0190D, IAB 4/1/26, effective 5/6/26]

7—2506.14(17A) Subpoenas.

2506.14(1) *Issuance.*

a. A presiding officer must issue a subpoena upon a party's written request. Unless there is good cause, a party must request a witness subpoena at least three days before the scheduled hearing. The request will include the name, address, email, and telephone number of the requesting party.

b. Except as otherwise set forth by law, parties are responsible for serving their own subpoenas and for paying witness fees and mileage expenses. Subpoenas that do not include the required witness fees and mileage expenses are not valid.

2506.14(2) *Motion to quash or modify.* The presiding officer may quash or modify a subpoena in accordance with the Iowa Rules of Civil Procedure. A motion to quash or modify a subpoena will be set for argument promptly.

[ARC 0190D, IAB 4/1/26, effective 5/6/26]

7—2506.15(17A) Motions.

2506.15(1) Motions are not required to be in a particular form. However, prehearing motions are to be in writing, state the grounds for relief, and state the relief sought.

2506.15(2) Any party may file a written response to a motion within ten days after the motion is served unless the time period is extended or shortened by rules of the agency or the presiding officer. The presiding officer may consider a failure to respond within the time period in ruling on a motion.

2506.15(3) The presiding officer may schedule oral argument on any motion.

2506.15(4) Unless there is good cause, motions pertaining to the hearing, except motions for summary judgment, must be filed and served at least ten days before the date of hearing. This time may be lengthened or shortened by rule of the agency or an order of the presiding officer.

2506.15(5) Motions for summary judgment.

a. Iowa Rules of Civil Procedure 1.981 through 1.983 govern motions for summary judgment, except where they conflict with this rule or legal requirements governing contested case proceedings.

b. Motions for summary judgment must be filed and served at least 45 days before the scheduled hearing date. Any party resisting the motion then has 15 days to file and serve a resistance. The time fixed for hearing or nonoral submission will be not less than 20 days after the filing of the motion. The presiding officer may by order change any of these deadlines. An order rendering summary judgment on all issues in a contested case is subject to rehearing pursuant to rule 7—2506.28(17A) and appeal pursuant to rule 7—2506.27(17A).

[ARC 0190D, IAB 4/1/26, effective 5/6/26]

7—2506.16(17A) Prehearing conference.

2506.16(1) Any party may request a prehearing conference. A written request for prehearing conference or an order for prehearing conference on the presiding officer's own motion will be filed not less than seven days before the hearing date. A prehearing conference will be scheduled not less than three business days before the hearing date. The presiding officer may change these deadlines for good cause.

2506.16(2) Witness and exhibit lists.

a. Each party will bring to the prehearing conference a final list of:

(1) The witnesses whom the party anticipates will testify at hearing. Unless there is good cause for the omission, the presiding officer may exclude the testimony of unlisted witnesses; and

(2) Exhibits that the party anticipates will be introduced at hearing. Unless there is good cause for the omission, the presiding officer may exclude unlisted, non-rebuttal exhibits.

b. Witness or exhibit lists may be amended subsequent to the prehearing conference within the time limits established by the presiding officer at the prehearing conference. Any such amendments are to be served on all parties.

2506.16(3) The parties at a prehearing conference may:

a. Stipulate to law or fact;

b. Stipulate to the admissibility of exhibits;

c. Identify matters that the parties intend to request be officially noticed;

d. Consider any additional matters that will expedite the hearing.

2506.16(4) Prehearing conferences will be conducted by telephone unless otherwise ordered. Parties are obligated to exchange and receive witness and exhibit lists before the conference.

[ARC 0190D, IAB 4/1/26, effective 5/6/26]

7—2506.17(17A) Continuances. Applications for continuances can be made to the presiding officer.

2506.17(1) A written application for a continuance will:

a. Be made at the earliest possible time and no less than seven days before the hearing, except in case of unanticipated emergencies;

b. State the specific reasons for the request; and

c. Be signed by the requesting party or the party's representative.

No application for continuance will be made or granted without notice to all parties, except in an emergency where notice is not feasible. The agency may waive notice of such requests for a particular case or an entire class of cases.

2506.17(2) In determining whether to grant a continuance, the presiding officer may consider:

- a. Prior continuances;
- b. The interests of all parties;
- c. The likelihood of informal settlement;
- d. The existence of an emergency;
- e. Any objection;
- f. Any applicable time obligations;
- g. The existence of a conflict in the schedules of counsel, parties, or witnesses;
- h. The timeliness of the request; and
- i. Other relevant factors.

The presiding officer may order a party to furnish evidence of facts supporting or opposing the request.

[ARC 0190D, IAB 4/1/26, effective 5/6/26]

7—2506.18(17A) Withdrawals. A party requesting a contested case proceeding may withdraw that request only in accordance with agency rules. Unless otherwise provided, a withdrawal will be with prejudice.

[ARC 0190D, IAB 4/1/26, effective 5/6/26]

7—2506.19(17A) Intervention.

2506.19(1) Motion. A motion for leave to intervene in a contested case proceeding must state the grounds for the proposed intervention, the position and interest of the proposed intervenor, and the possible impact of intervention on the proceeding. The proposed intervenor must attach a proposed answer or petition in intervention, as appropriate, to the motion. Any party may file a response within 14 days of service of the motion to intervene unless the time period is extended or shortened by the presiding officer.

2506.19(2) When filed. A motion for leave to intervene must be filed as early as possible to avoid prejudice on existing parties or the conduct of the proceeding and, at any rate, before the prehearing conference, if any, or at least 20 days before the date scheduled for hearing. Later motions must show good cause for being untimely. Unless inequitable or unjust, an intervenor is bound by any agreement, arrangement, or other matter previously raised in the case. Requests by untimely intervenors for continuances that would delay the proceeding will ordinarily be denied.

2506.19(3) Grounds for intervention. The proposed intervenor must show that:

- a. Intervention would not unduly prolong the proceedings or otherwise prejudice the rights of existing parties;
- b. It is likely to be aggrieved or adversely affected by a final order in the proceeding; and
- c. Its interests are not adequately represented by existing parties.

2506.19(4) Effect of intervention. A person granted leave to intervene is a party to the proceeding. If appropriate, the presiding officer may order consolidation of the petitions and briefs of different parties whose interests are aligned with each other and limit the number of representatives allowed to participate actively in the proceedings. The order granting intervention may limit the issues the intervenor is allowed to raise or otherwise condition the intervenor's participation in the proceeding.

[ARC 0190D, IAB 4/1/26, effective 5/6/26]

7—2506.20(17A) Hearing procedures.

2506.20(1) The presiding officer presides at the hearing and may rule on motions, impose obligations to submit briefs, issue a proposed decision, and issue orders and rulings to ensure the orderly conduct of the proceedings.

2506.20(2) All objections must be made timely and stated on the record.

2506.20(3) Parties have the right to participate or to be represented in all hearings or prehearing conferences related to their case. Partnerships, corporations, limited-liability companies, and associations may be represented by any member, officer, director, or duly authorized agent. Any

party may be represented by an attorney or another person authorized by law. An attorney admitted pro hoc vice in accordance with the Iowa rules of court to practice in an agency administrative action in accordance with Iowa Court Rule 31.14 is obligated to have an in-state attorney present at every interaction with the presiding officer.

2506.20(4) Subject to terms and conditions prescribed by the presiding officer, parties have the right to introduce evidence on issues of material fact, cross-examine witnesses present at the hearing as necessary for a full and true disclosure of the facts, present evidence in rebuttal, and submit briefs and engage in oral argument.

2506.20(5) The presiding officer will maintain the decorum of the hearing and may refuse to admit or may expel anyone whose conduct is disorderly.

2506.20(6) Witnesses may be sequestered during the hearing.

2506.20(7) The presiding officer must conduct the hearing in the following manner:

a. The presiding officer will give an opening statement briefly describing the nature of the proceedings;

b. The parties will be given an opportunity to present opening statements;

c. Parties will present their cases in the sequence determined by the presiding officer;

d. Each witness will be sworn or affirmed by the presiding officer or the court reporter and be subject to examination and cross-examination. The presiding officer may limit questioning in a manner consistent with law;

e. When all parties and witnesses have been heard, parties may be given the opportunity to present final arguments.

[ARC 0190D, IAB 4/1/26, effective 5/6/26]

7—2506.21(17A) Evidence.

2506.21(1) The presiding officer will rule on admissibility of evidence as provided in Iowa Code section 17A.14 and may, where appropriate, take official notice of facts in accordance with all applicable legal obligations.

2506.21(2) Stipulation of facts is encouraged. The presiding officer may make a decision based on stipulated facts.

2506.21(3) Evidence in the proceeding will be confined to the issues identified at the prehearing conference or in the notice of hearing, as appropriate. A party may waive its right to prehearing notice. The presiding officer may, for good cause, expand the issues to be considered and admit evidence on those issues. In that case, a party that objects to the expansion is, upon timely request, entitled to a continuance sufficient to amend pleadings and to prepare on the additional issue.

2506.21(4) The presiding officer will not rule on the admissibility of an exhibit until opposing parties have had an opportunity to examine it. Parties should ordinarily furnish copies of exhibits to opposing parties before a hearing to prevent unnecessary delay during the hearing. All exhibits admitted into evidence will be appropriately marked and made part of the record.

2506.21(5) Any party may object to specific evidence or request limits on the scope of any examination or cross-examination. Each objection must be accompanied by a brief statement of the grounds upon which it is based. The objection, the ruling on the objection, and the reasons for the ruling will be noted in the record. The presiding officer may rule on the objection when it is made or may reserve a ruling until the written decision.

2506.21(6) Whenever evidence is ruled inadmissible, the party offering that evidence may submit an offer of proof on the record. The party making the offer of proof for excluded oral testimony will briefly summarize the testimony or, with permission of the presiding officer, present the testimony. If the excluded evidence is a document or exhibit, it will be marked as part of an offer of proof and inserted in the record.

[ARC 0190D, IAB 4/1/26, effective 5/6/26]

7—2506.22(17A) Default.

2506.22(1) If a party does not appear or participate in a contested case proceeding after proper notice, the presiding officer may render a default or proceed with the hearing and render a decision in the absence of the party.

2506.22(2) Where appropriate, any party may move for default against a party who has requested the contested case proceeding and has not filed a necessary pleading or has not appeared after proper service.

2506.22(3) Default decisions and decisions rendered on the merits after a party has not appeared or participated are final agency actions from which a party may appeal under rule 7—2506.27(17A). A party against whom such a decision has been rendered may file a motion to vacate within 15 days, or other period specified by statute, after the date of notification or mailing of the decision. A motion to vacate must state all facts that establish good cause for that party's non-appearance or non-participation. Each such fact must be supported by at least one sworn affidavit of a person with personal knowledge, which affidavit must be attached to the motion.

2506.22(4) The time for further appeal of a decision is stayed while a timely motion to vacate is pending.

2506.22(5) A presiding officer may grant a motion to vacate only if it is timely and establishes good cause for the movant's non-appearance or non-participation. The burden of proof as to good cause is on the moving party. Opposed parties have ten days to respond to a motion to vacate. If the response includes a request to do so, an opposing party may conduct discovery into the issue of good cause and present evidence on that issue before the presiding officer decides the motion.

2506.22(6) "Good cause" for purposes of this rule has the same meaning as "good cause" for setting aside a default judgment under Iowa Rule of Civil Procedure 1.977.

2506.22(7) A decision denying a motion to vacate is subject to further appeal within the time limit allowed for further appeal of a decision on the merits in the contested case proceeding. A decision granting a motion to vacate is subject to interlocutory appeal by the adverse party pursuant to rule 7—2506.25(17A).

2506.22(8) If a motion to vacate is granted, and no timely interlocutory appeal has been taken, the presiding officer will issue another notice of hearing and the contested case will proceed accordingly.

2506.22(9) A default decision may award any relief consistent with the request for relief made in the petition and embraced in its issues.

2506.22(10) A default decision may provide either that the default decision is to be stayed pending a timely motion to vacate or that the default decision is to take effect immediately, subject to a request for stay under rule 7—2506.29(17A).

[ARC 0190D, IAB 4/1/26, effective 5/6/26]

7—2506.23(17A) Ex parte communication.

2506.23(1) Improper communications. Except as specifically allowed by law, no party, representative of a party, or person with a direct or indirect interest in a case may communicate, directly or indirectly, with the presiding officer, or vice versa, regarding the case or a pending factually related case. These communications are allowed only if all parties have been notified of the intention to communicate and have an opportunity to participate. This does not prohibit persons jointly assigned such tasks from communicating with each other. However, the presiding officer may communicate with members of the agency and may seek the advice or help of persons regarding the matter. This can include persons with whom the presiding officer is prohibited from communicating in another case, as long as the presiding officer's communications with that person are not regarding that other case or a case factually related to it.

2506.23(2) Written, oral, or other forms of communication are "ex parte" if made without notice and opportunity for all parties to participate.

2506.23(3) These prohibitions start when the notice of hearing is issued and continue for as long as the case is pending.

2506.23(4) To avoid banned ex parte communications, notice is to be given in a manner reasonably calculated to give all parties a fair opportunity to participate. Notice of written communications will be provided in compliance with rule 7—2506.12(17A) and may be supplemented by telephone, fax, email or other means of notification. Where permitted, oral communications may be initiated through conference telephone call including all parties or their representatives.

2506.23(5) Persons who jointly act as presiding officer in a pending contested case may communicate with each other without notice or opportunity for parties to participate.

2506.23(6) The administrator or other persons may be present in deliberations or otherwise advise the presiding officer without notice or opportunity for parties to participate as long as they are not disqualified from participating in the making of a proposed or final decision and they comply with subrule 2506.23(1).

2506.23(7) Communications with the presiding officer involving uncontested scheduling or procedural matters do not need notice or opportunity for parties to participate. Parties should notify other parties prior to initiating such contact with the presiding officer when possible and must notify other parties when seeking to continue hearings or other deadlines.

2506.23(8) Disclosure of banned communications. A presiding officer who receives a banned ex parte communication while a contested case is pending must first determine whether the communication is so prejudicial that the presiding officer should be disqualified. If so, the presiding officer will enter into the record, sealed by a protective order, a copy of any banned written communication, all written responses to the communication, a written summary of the substance of any banned oral or other communication, all responses made, and the identity of each person from whom the presiding officer received a banned ex parte communication. If the presiding officer determines that disqualification is not warranted, the presiding officer will enter these documents into the record and serve them upon all parties. Any party desiring to rebut the banned communication will be allowed the opportunity to do so upon written request filed within ten days after notice of the communication.

2506.23(9) Promptly after being assigned to serve as presiding officer at any stage in a contested case proceeding, a presiding officer must disclose to all parties material factual information received through ex parte communication before the assignment began. The presiding officer does not need to disclose this information if it has already been, or shortly will be, disclosed under Iowa Code section 17A.13(2) or through discovery or if it is contained in an investigative report or similar document that has been or shortly will be given to the parties.

2506.23(10) The presiding officer may render a proposed or final decision imposing appropriate sanctions for violations of this rule including default, a decision against the offending party, censure, or suspension or revocation of the privilege to practice before the agency. Violation of ex parte communication obligations by agency personnel will be reported to the chief executive of the agency or that person's designee for possible sanctions including censure, suspension, dismissal, or other disciplinary action.

[ARC 0190D, IAB 4/1/26, effective 5/6/26]

7—2506.24(17A) Recording costs. Upon reasonable request, the agency is obligated to provide a copy of the whole or any portion of the record at cost. The cost of preparing a copy of the record or of transcribing the hearing record will be paid by the requesting party. A party that requests that a hearing be recorded by certified shorthand reporter rather than by electronic means is responsible for making such arrangements and paying associated costs unless otherwise provided by applicable law.

[ARC 0190D, IAB 4/1/26, effective 5/6/26]

7—2506.25(17A) Interlocutory appeals. Upon written request of a party or on its own motion, the agency may review an interlocutory order. In determining whether to do so, the agency must weigh the extent to which the granting of the interlocutory appeal would expedite final resolution of the case and the extent to which review of that interlocutory order by the agency at the time it reviews

the proposed decision of the presiding officer would provide an adequate remedy. A request for interlocutory review must be filed by the earliest of 14 days after the challenged order is issued, the deadline for complying with the order, or the date of hearing.

[ARC 0190D, IAB 4/1/26, effective 5/6/26]

7—2506.26(17A) Final decision.

2506.26(1) When the agency presides over receiving evidence at the hearing, its decision is a final decision.

2506.26(2) When the agency does not preside over receiving evidence, the presiding officer will issue a proposed decision. The proposed decision becomes the final decision of the agency without further proceedings unless there is an appeal of the proposed decision to the agency, or review of the proposed decision on the agency's own motion, in accordance with rule 7—2506.27(17A).

[ARC 0190D, IAB 4/1/26, effective 5/6/26]

7—2506.27(17A) Appeals and review.

2506.27(1) *Appeal by party.* Any adversely affected party may appeal a proposed decision to the agency within 30 days after the decision is issued.

2506.27(2) *Review.* The agency may initiate review of a proposed decision on its own motion at any time within 30 days following the issuance of such a decision.

2506.27(3) *Notice of appeal.* An appeal of a proposed decision is initiated by filing a timely notice of appeal with the agency. The notice of appeal is to be signed by the appealing party or a representative of that party and contain a certificate of service. The notice will specify:

- a. The parties initiating the appeal;
- b. The proposed decision or order appealed from;
- c. The specific findings or conclusions to which exception is taken and any other exceptions to the decision or order;
- d. The relief sought; and
- e. The grounds for relief.

2506.27(4) *Requests to present additional evidence.* A party may request to submit additional evidence. The request must be filed with the notice of appeal, if by an appealing party, or within 14 days of service of the notice of appeal, if by a non-appealing party. The agency will take additional evidence only if the party establishes that the evidence is material, that good cause existed for its not being presented at the hearing, and that the party has not waived the right to present the evidence. The agency may remand a case to the presiding officer to take additional evidence or may itself preside at the taking of additional evidence.

2506.27(5) *Scheduling.* The agency will issue a schedule for consideration of the appeal.

2506.27(6) *Briefs and arguments.* Unless otherwise ordered, within 20 days of the notice of appeal or order for review, each appealing party may file exceptions and briefs. Within 20 days thereafter, any party may file a responsive brief. Briefs will include any applicable legal authority and specify relevant portions of the record in that proceeding. Written requests to present oral argument will be filed with the briefs. The agency may resolve the appeal on the briefs or provide an opportunity for oral argument. The agency may shorten or extend the briefing period as appropriate.

[ARC 0190D, IAB 4/1/26, effective 5/6/26]

7—2506.28(17A) Applications for rehearing.

2506.28(1) *By whom filed.* Any party to a contested case proceeding may file an application for rehearing from a final order.

2506.28(2) *Content of application.* The application for rehearing must identify on whose behalf it is filed, the portion of the decision the party wants reconsidered, the specific grounds for rehearing, whether the party wants to proceed on the record or to submit additional evidence, and the relief sought.

2506.28(3) *Time of filing.* The deadline to file an application for rehearing is 20 days after the final decision is issued.

2506.28(4) *Notice to other parties.* A copy of the application will be timely mailed or emailed by the applicant to all parties of record not joining therein. If the application does not contain a certificate of service, the agency will serve copies on all parties.

2506.28(5) *Disposition.* A party need not respond to an application for rehearing unless the government entity requests a response. An application for a rehearing is deemed denied if it is not granted within 20 days of its filing or, if a response is filed, within 20 days of the filing of a response. An application for rehearing is optional; a party need not file an application to exhaust available administrative remedies. The filing of an application for rehearing shall toll the time period for appeal in rule 7—2506.27(17A).

[ARC 0190D, IAB 4/1/26, effective 5/6/26]

7—2506.29(17A) Stays of agency actions.

2506.29(1) *When available.*

a. Any party may petition the agency to stay the effect of an order, or for other temporary remedies, pending review of the order by the agency. The petition must be filed with the notice of appeal and must state the reasons justifying a stay or other temporary remedy. The agency may rule on the stay or authorize the presiding officer to do so.

b. Any party may petition the agency for a stay, or other temporary remedies, pending judicial review of all or part of that proceeding. The petition must state the reasons justifying a stay or other temporary remedy.

2506.29(2) *When granted.* The presiding officer or agency will consider the factors listed in Iowa Code section 17A.19(5) “c” when deciding whether to grant the stay or other temporary remedy.

2506.29(3) *Vacation.* The presiding officer or agency may vacate a stay or other temporary remedy on the motion of the agency or any other party.

[ARC 0190D, IAB 4/1/26, effective 5/6/26]

7—2506.30(17A) Contested cases involving no factual dispute. If the parties agree that no dispute of material fact exists, they may present all evidence, by stipulation or as otherwise agreed, without an evidentiary hearing. In such a situation, the parties should, as soon as practicable, jointly submit a proposed schedule for submitting the record and briefs and, if necessary, holding oral argument. If the parties cannot agree to a schedule, any party may file and serve a motion for summary judgment.

[ARC 0190D, IAB 4/1/26, effective 5/6/26]

7—2506.31(17A) Emergency adjudicative proceedings.

2506.31(1) *Necessary emergency action.* To the extent necessary to prevent or avoid immediate danger to the public health, safety, or welfare and, consistent with the Constitution and other provisions of law, the agency may issue an emergency adjudicative order in compliance with Iowa Code section 17A.18A. The order must be in writing and may suspend a license in whole or in part, order that any continuing activity stop, order someone to act, or require other action within the jurisdiction of the agency. Before issuing an emergency adjudicative order, the agency must consider factors such as:

a. Whether there has been a sufficient factual investigation to ensure that it is proceeding on the basis of reliable information;

b. Whether the specific circumstances that pose immediate danger to public health, safety, or welfare have been identified and determined to be continuing;

c. Whether the person subject to the proposed emergency adjudicative order may continue to engage in other activities without posing immediate danger to public health, safety, or welfare;

d. Whether imposition of monitoring obligations or other interim safeguards would be sufficient to protect the public health, safety, or welfare; and

e. Whether the specific action contemplated by the agency is necessary to avoid immediate danger.

2506.31(2) *Issuance of order.*

a. An emergency adjudicative order must contain findings of fact and conclusions of law to justify the determination of an immediate danger in the agency's decision to take immediate action.

b. The emergency adjudicative order will be immediately delivered to persons obligated to comply with the order by one or more of:

(1) Personal delivery;

(2) First-class or certified mail to the last address on file with the agency; or

(3) Fax. Fax may be used as the sole method of delivery if the person to whom the order applies has filed a written request that agency orders be sent by fax and has provided a fax number for that purpose.

c. To the practicable degree, the agency is obligated to select the procedure for providing written notice that best ensures prompt, reliable delivery.

2506.31(3) *Oral notice.* Unless the emergency adjudicative order is served by personal delivery on the same day that it is issued, the agency is obligated to make reasonable immediate efforts to contact the people to whom the order applies by telephone.

2506.31(4) *Completion of proceedings.*

a. After the issuance of an emergency adjudicative order, the agency will proceed as quickly as feasible to complete any proceedings that would be needed if the matter did not involve an immediate danger.

b. An emergency adjudicative order must include, or be accompanied by, a notice of the date by which agency proceedings are scheduled for completion. When an agency has issued an emergency adjudicative order, the agency or a presiding officer may continue contested case proceedings only in compelling circumstances upon application in writing.

[ARC 0190D, IAB 4/1/26, effective 5/6/26]

7—2506.32 to 2506.100 Reserved.

7—2506.101(17A) Definitions for vendor appeals of contested cases. As used in this chapter, unless the context otherwise dictates:

“Agency” means the agency when purchasing goods or services through a competitive solicitation.

“Award” means the decision to select a vendor for a contract or purchase.

“Vendor” means any vendor who has submitted a bid or proposal in response to a competitive solicitation issued by an agency.

[ARC 0190D, IAB 4/1/26, effective 5/6/26]

7—2506.102(17A) Vendor appeal process. Rules 7—2506.101(17A) through 7—2506.105(17A) govern appeals of the agency's decisions regarding competitive solicitations for goods or services. These rules supplement standard contested case rules and control to the extent inconsistent with standard contested case rules. Not complying with these vendor appeal rules in any material respect will result in dismissal of the appeal and constitute a failure to exhaust administrative remedies.

2506.102(1) *Notice of intent to appeal.* A vendor who is aggrieved by the agency's issuance of a notice of intent to award following a competitive solicitation may appeal that notice of intent to award. The deadline for the vendor to submit a notice of intent to appeal is five days following issuance of the notice of intent to award. Late notices of intent to appeal will not be accepted.

2506.102(2) *Initial disclosures.* When an agency receives the vendor's notice of intent to appeal, the agency will respond by providing the public version of the winning vendor's proposal as submitted by the vendor during the solicitation process. In addition, the agency will provide all evaluation committee materials, documentation, analysis, and results. If requested by the vendor, the agency will also send the public versions of losing bids or proposals as those public copies were submitted

during the solicitation process. The vendor is not entitled to any additional discovery, materials, or information unless the proceedings advance past the first-tier review stage.

2506.102(3) *Notice of appeal.* Following receipt of the initial disclosures, the vendor may file a formal appeal within either the time frame identified in the solicitation document or, if no time frame is identified, five days from the award. If the vendor does not file a formal appeal in a timely manner, the appeal is waived. The vendor is obligated to plead with particularity; notice pleading is inadequate. At minimum, the formal appeal will include:

- a.* The vendor's contact information, including contact information for the individual filing the notice of appeal, the individual's association with the appealing vendor, and a showing of the individual's authority to appeal on behalf of the appealing vendor;
- b.* Details of the award decision the vendor is challenging;
- c.* Why and how the vendor is aggrieved by the decision;
- d.* The legal and factual reasons for the vendor's appeal, including references to the relevant grounds of appeal as set forth in Iowa Code section 17A.19(10); and
- e.* The relief the vendor is seeking.

2506.102(4) *Appeal bond—notice of appeal, first-tier review.* At the same time the vendor submits the notice of appeal, the appealing vendor must submit to the agency an appeal bond to the extent required in the solicitation document. An agency has discretion to require a bond in an amount up to 5 percent of the value of the contract that is the subject of the appeal, including all extension years available under the contract awarded. If the vendor does not submit the appeal bond, the agency will dismiss the appeal. The vendor forfeits the appeal bond if its claims are determined to be unreasonable, frivolous, or for purposes of delaying the award, in which case the vendor will also be ordered to pay all costs of the appeal of the agency and any intervening party. Those costs include but are not limited to the costs of the process, hearing costs, expert witness fees, and attorney's fees and costs. The appealing vendor may be disqualified from future competitive solicitations in accordance with applicable rules addressing vendor disqualification through debarment or suspension if the appeal is determined to be unreasonable, frivolous, or for the purpose of delay. Awarded costs may be extracted from the appeal bond.

2506.102(5) *Public records.*

a. To ensure fair evaluation of proposals and to make the vendor appeal process more efficient, solicitation-related information, such as proposals and evaluation materials, will remain confidential and will not be released to the public until the notice of intent to award is issued or any vendor appeals are fully and finally resolved, whichever comes later. Materials released in accordance with these vendor appeal rules or in a formal sealed bidding process controlled by Iowa Code section 72.3 are exceptions to this temporary prohibition on the release of confidential information.

b. By submitting materials for the bidding process, a vendor agrees that submitted documents and information can be shared with third parties, including competitors, in the event of an appeal. However, the agency will share confidential or proprietary information during an appeal process only in accordance with a protective order acceptable to the agency. Without a protective order, the agency will make available only to litigants copies of proposals from which confidential and proprietary information have been redacted, and then to non-litigants only after finalization of the award process or all vendor appeals, whichever comes later.

c. A vendor's notice of appeal is a public document available for public inspection. If the vendor believes the notice contains any confidential information, the vendor must, when it submits the notice of appeal, explain why the notice should remain confidential. The vendor must also submit a redacted version of the notice of appeal so that the public and other vendors submitting proposals in response to the solicitation can view nonconfidential portions of the notice of appeal.

2506.102(6) *Notice to winning vendor and intervention.* Once the agency receives the notice of appeal, the issuing officer for the solicitation will notify the winning vendor. The winning vendor may intervene in the appeal by submitting a notice of intervention no later than five days after receiving the notice.

2506.102(7) *Initial disclosures to intervenors.* The agency will send the intervening vendor the same public documents sent to the appellant.

2506.102(8) *Waiver.* To facilitate an orderly and timely resolution of vendor appeals, claims are waived in each of these instances:

- a. A vendor did not raise during the solicitation process, such as through a question-and-answer period, an issue that could have been addressed during that process;
- b. The issue is not raised in the original notice of appeal; and
- c. An argument that could have been raised at an earlier stage of the appeal was not raised at that earlier stage.

[ARC 0190D, IAB 4/1/26, effective 5/6/26]

7—2506.103(17A) Vendor appeal stages.

2506.103(1) *First-tier review.* Once the appeal is filed and any responses are received, the agency will review the case internally and issue a decision upholding, changing, or reversing the original award decision. The agency's decision is final unless the appealing vendor requests a second-tier review within the time frame identified in the solicitation document for seeking second-tier review or, if no time frame is so identified, five days from the issuance of the first-tier review. Failure to seek a second-tier review constitutes waiver of any right to seek a second-tier review and failure to exhaust administrative remedies.

2506.103(2) *Second-tier review.*

a. *Appeal hearing.* A vendor aggrieved by an agency's first-tier review may seek a second-tier review by filing a notice seeking second-tier review with the agency within five days of issuance of the first-tier review decision. The second-tier review request must comply with subrule 2506.102(3), except that it must refer to the first-tier review decision instead of the award decision. Upon receipt of a vendor's request for a second-tier review, the agency will schedule a hearing before an administrative law judge from the department of inspections, appeals, and licensing. The second-tier review hearing will be held within 60 days after the request for a second-tier review, subject to good cause exceptions as set forth in subrule 2506.3(2).

b. *Appeal security.* At the same time as it submits a second-tier review request, the appealing vendor must submit an additional appeal bond to the extent required in the solicitation document. An agency has discretion to require a second bond in an amount up to 10 percent of the value of the contract that is the subject of the appeal, including all extension years available under the contract awarded. If the vendor does not satisfy the bond requirement, the agency will dismiss the second-tier review. The appeal bond will be forfeited if the vendor's claims are determined to be unreasonable, frivolous, or for purposes of delaying the award.

c. *Discovery.* Any party may seek reasonable discovery of information directly relevant to the issues that are the subject of the appeal. Overly broad or burdensome discovery requests are not allowed. Discovery issued to the agency is limited to events occurring at the agency that relate to the solicitation process. Issues not subject to discovery include the agency's existing relationships with other bidders. As a condition of requesting a second-tier review, the appellant is obligated to promptly respond to discovery requests made by any party defending the award. Any party defending the award may seek discovery from appellant of any matters that could affect the fairness of the solicitation process, including whether the appellant failed to disclose information relevant to the award process that would have resulted in its disqualification or that appellant engaged in previously unreported inappropriate contact that would have resulted in its disqualification. An appellant that would have been disqualified is not prejudiced by the award decision and lacks standing to challenge it. Confidential or proprietary information may be shared by the parties to the appeal in accordance with a protective order acceptable to the agency. All discovery requests will be made no later than five days after the request for a second-tier review is submitted. Parties must completely respond or object to discovery requests within 30 days of receipt. A party that objects to discovery requests must submit its objection to the requesting parties within ten days of receiving the discovery requests.

Sanctions will be imposed for abuse of the discovery process, potentially including adverse inferences and dismissal of the appeal.

d. Witnesses and exhibits. At least ten days before the hearing, the parties will contact each other to discuss proposed witnesses and exhibits. Final witness and exhibit lists will be exchanged no later than seven days before the hearing.

e. Second-tier hearing and decision. The hearing will be transcribed by a court reporter arranged and paid for by the parties with the costs shared equally unless all parties to an appeal and the presiding officer agree to an alternative approach to record the proceeding. In the event the presiding officer orders post-hearing briefing, the following post-hearing schedule applies unless the parties agree to and the presiding officer orders a different schedule:

- (1) Any appellant post-hearing brief is due ten days after the presiding officer closes the record;
- (2) Any appellee or intervenor post-hearing brief is due ten days after receiving the appellant's brief, if any; and
- (3) Any appellant reply brief is due ten days after receiving the appellee or intervenor post-hearing brief.

Following the close of post-hearing briefing, the administrative law judge will issue a proposed decision, which will become the final agency decision unless a party seeks a third-tier review.

2506.103(3) *Third-tier review and decision.* A party aggrieved by an agency's second-tier review may seek a third-tier review by filing a notice seeking third-tier review with the agency. The deadline to file this notice is five days after the proposed decision on the second-tier review is issued. The third-tier review request must comply with subrule 2506.102(3), except that it must refer to the second-tier review decision instead of the award decision. The party appealing must submit the entire record from the second-tier review, including any transcripts or recordings, at its own cost. Any non-appealing party may file a response to the request. No additional briefing or argument is allowed at the third-tier review stage absent an agency's request. The agency will thereafter expeditiously issue the final agency decision, which will constitute final agency action on the matter.

[ARC 0190D, IAB 4/1/26, effective 5/6/26]

7—2506.104(17A) Standards and remedies for vendor appeals.

2506.104(1) *Standard of review.* In all stages of the vendor appeal, the standard of review will be whether the solicitation process substantially complied with the legally binding procedures applicable to the award process at issue and, if not, whether there is prejudice to the nonprevailing vendor because:

- a.* The noncompliance demands a conclusion that the award process was not conducted fairly, openly, or objectively, and
- b.* Compliance with the legally binding procedure would have resulted in a different outcome.

For purposes of this rule, "legally binding procedure" means those procedures mandated by statute or administrative rule or expressly set forth in the text of the competitive solicitation. Agency guidance that is not in statute, administrative rule, or the text of the solicitation, including but not limited to training materials and procedural manuals, does not constitute legally binding procedure.

2506.104(2) *Burdens.* The appealing vendor bears the burden of proof and the burden of producing evidence in support of its allegations.

2506.104(3) *Standard of proof and prejudice to vendor.* The vendor must prove both noncompliance and prejudice by clear and convincing evidence.

2506.104(4) *Remedies available.* If the solicitation process is found to be unfair or noncompliant with legally binding procedures, the remedy will be narrowly tailored and specifically designed to remediate the specific noncompliance. Wholesale remedies invalidating or voiding solicitations will be avoided unless no other conceivable measure could remediate the noncompliance. Possible remedies may include but are not necessarily limited to remand to the agency with directions to remedy the specific noncompliance and reissue the award if the agency determines the contract is still necessary to meet the agency's needs or objectives or, if remediation of the noncompliance is not

possible, voiding the notice of intent to award with directions to the agency to proceed in the state's best interests, which may include canceling the solicitation.

2506.104(5) *Authority over award decisions.* All final award decisions will be made by the agency. An administrative law judge's authority is limited to affirming the agency's action or remanding the issue to the agency for further consideration through a proposed decision. An administrative law judge lacks jurisdiction to compel the issuance of an award to a vendor other than a vendor awarded a contract by the agency.

2506.104(6) *Issues not for consideration.* The following types of challenges are not a basis for a vendor appeal. An attempted appeal that fits within one of the following categories will be dismissed:

a. Any claim related to existing contract administration. The administration of an existing contract is within the discretion of the agency. Disputes between a vendor and the agency are resolved in accordance with dispute-resolution clauses in a contract and not through a vendor appeal process.

b. Any claim of a subcontractor of an aggrieved vendor. Only vendors who submitted a bid or proposal in response to a solicitation have standing to appeal a notice of intent to award.

c. Any claim related to alternative procurement processes, such as purchase orders, statements of work, or other transactional documents executed under an existing contract, including such orders made under master agreements. Vendor appeals are allowed only in response to competitive solicitations and no other forms of state purchases.

d. Any claim related to suspensions or debarments of vendors.

[ARC 0190D, IAB 4/1/26, effective 5/6/26]

7—2506.105(17A) Stay of agency action.

2506.105(1) *When a vendor can request a stay.* A vendor appealing a notice of intent to award may request a stay of the award process by filing a request for stay with the notice of appeal. In requesting the stay of agency action, the vendor is obligated to submit an additional bond equal to 120 percent of the value of the contract at issue, including any extension years available under the awarded contract. This bond is in addition to other appeal bonds as set forth in this chapter. If the appealing vendor does not submit a sufficient bond with its request for stay, its request for stay will be denied and the issue of stay of agency action will be considered waived. If no stay is sought or the issue is deemed waived, the agency will proceed with the contract award and contract execution consistent with the notice of intent to award. The vendor forfeits the appeal bond if its claims are determined to be unreasonable, frivolous, or for purposes of delaying the award, in which case the vendor will also be ordered to pay all costs of the appeal of the agency and any intervening party. Those costs include but are not limited to the costs of the process, hearing costs, expert witness fees, and attorney's fees and costs. Awarded costs may be extracted from the appeal bond. If a stay is not granted and the ultimate award to the incoming awardee overturned in an administrative appeal or on judicial review, the contracted vendor will be entitled to payment for goods and services rendered under the contract and the agency may continue the contract with the awarded vendor until a replacement vendor is under contract.

2506.105(2) *When the stay is granted.* The agency will consider factors set forth in Iowa Code section 17A.19(5)“c” in deciding whether to grant the stay. The agency's decision on whether to grant a stay will be made by the chief executive of the agency and will constitute final agency action on the request for stay for purposes of Iowa Code chapter 17A.

2506.105(3) *When the stay is vacated.* Any stay imposed on an award may be vacated upon application of the agency or another interested party upon a showing of good cause.

[ARC 0190D, IAB 4/1/26, effective 5/6/26]

7—2506.106(17A) Federal funds.

2506.106(1) Rules 7—2506.101(17A) through 7—2506.105(17A) do not apply where they conflict with a governing federal regulation or would jeopardize the receipt of federal funds.

2506.106(2) If the attorney general determines that any portion of rules 7—2506.101(17A) through 7—2506.105(17A) would cause the federal government to deny funds or services that would

otherwise be available to an agency of this state, that portion will be suspended for that agency but only to the extent necessary to prevent denial of the federal funds or services.

[ARC 0190D, IAB 4/1/26, effective 5/6/26]

These rules are intended to implement Iowa Code chapter 17A.

[Filed Emergency ARC 0038D, IAB 2/4/26, effective 1/13/26]

[Filed ARC 0190D (Notice ARC 0037D, IAB 2/4/26), IAB 4/1/26, effective 5/6/26]

[Editorial change: IAC Supplement 5/27/26]

CHAPTER 55
LICENSING OF PUBLIC ADJUSTERS

Chapter exempt from chapter rescission pursuant to Iowa Code section 17A.7

191—55.1(522C) Purpose. The purpose of this chapter is to govern the qualifications and procedures for licensing public adjusters in this state and to specify the duties of and restrictions on public adjusters, including limitation of such licensure to assisting only insureds with first-party claims.

[ARC 5250C, IAB 11/4/20, effective 12/9/20]

191—55.2(522C) Definitions. In addition to the definitions in Iowa Code section 522C.2 and rule 191—1.1(502,505), the following definitions apply, unless the context otherwise requires:

“Catastrophic disaster,” according to the Federal Response Plan, means an event that results in large numbers of deaths and injuries; causes extensive damage or destruction of facilities that provide and sustain human needs; produces an overwhelming demand on state and local response resources and mechanisms; causes a severe long-term effect on general economic activity; and severely affects state, local and private sector capabilities to begin and sustain response activities. A catastrophic disaster shall be declared by the President of the United States or the governor of the state or district in which the disaster occurred.

“First-party claim” means the same as defined in Iowa Code section 522C.2.

“Home state” means the District of Columbia and any state or territory of the United States in which the public adjuster’s principal place of residence or principal place of business is located. If neither the state in which the public adjuster maintains the principal place of residence nor the state in which the public adjuster maintains the principal place of business has a substantially similar law governing public adjusters, the public adjuster may declare another state in which it becomes licensed and acts as a public adjuster to be the “home state.”

“Insured” means a person covered under the insurance policy against which the claim is made.

“NAIC” means the National Association of Insurance Commissioners.

“National Insurance Producer Registry” or *“NIPR”* means the nonprofit affiliate of the National Association of Insurance Commissioners (NAIC). The NIPR’s website is www.NIPR.com.

“NIPR Gateway” means the communication network developed and operated by the National Insurance Producer Registry that links state insurance regulators with the entities they regulate to facilitate the electronic exchange of, among other things, public adjuster information regarding license applications, license renewals, appointments and terminations.

“Producer database” means the national database of insurance producers maintained by the NAIC.

“Public adjuster” means the same as defined in Iowa Code section 522C.2.

[ARC 5250C, IAB 11/4/20, effective 12/9/20]

191—55.3(522C) License required to operate as public adjuster.

55.3(1) A person shall not operate as or represent that the person is a public adjuster in this state unless the person is licensed by the division in accordance with this chapter.

55.3(2) A person licensed as a public adjuster in accordance with this chapter shall assist only insureds with first-party claims.

55.3(3) Notwithstanding subrule 55.3(1), a license as a public adjuster shall not be required of the following:

a. An attorney-at-law admitted to practice in this state, when acting in the attorney’s professional capacity as an attorney;

b. A person who negotiates or settles claims arising under a life or health insurance policy or an annuity contract;

c. A person employed only for the purpose of obtaining facts surrounding a loss or furnishing technical assistance to a licensed public adjuster, including photographers, estimators, private investigators, engineers and handwriting experts;

d. A licensed health care provider, or an employee of a licensed health care provider, who prepares or files a health claim form on behalf of a patient; or

e. A person who settles subrogation claims between insurers.

[ARC 5250C, IAB 11/4/20, effective 12/9/20]

191—55.4(522C) Application for license.

55.4(1) A person applying for a public adjuster license shall make application on a uniform individual application or uniform business entity application available through the NIPR Gateway, or as otherwise directed by the division.

55.4(2) Each individual resident applying for a public adjuster license shall submit to a criminal history check pursuant to Iowa Code section 522B.5A.

[ARC 5250C, IAB 11/4/20, effective 12/9/20]

191—55.5(522C) Issuance of resident license.

55.5(1) *License of individual.* Before approving an individual's application, the division shall find that the applicant:

a. Either is eligible to designate this state as the individual's home state, or is a nonresident who is not eligible for a license under rule 191—55.8(522C);

b. Has not committed any act that could result in denial, suspension or revocation of a license as set forth in rule 191—55.12(522C);

c. Is trustworthy, reliable, and of good reputation, evidence of which may be determined by the division;

d. Is financially responsible to exercise the license and has provided proof of financial responsibility as required in rule 191—55.10(522C);

e. Has paid the fees set forth in rule 191—55.20(522C);

f. Maintains an office in the home state of residence with public access by reasonable appointment or regular business hours;

g. Is at least 18 years of age;

h. Has successfully passed the public adjuster examination pursuant to rule 191—55.6(522C); and

i. Has submitted to the division the contract the applicant intends to use pursuant to rule 191—55.14(522C).

55.5(2) *License of business entity.* Before approving a business entity's application, the division shall find that the business entity has:

a. Paid the fees set forth in rule 191—55.20(522C);

b. Designated a licensed public adjuster responsible for the business entity's compliance with the insurance laws, rules and regulations of this state;

c. Designated a licensed individual public adjuster responsible for the business entity's compliance with the insurance laws, rules, and regulations of this state; and

d. Submitted to the division the contract the applicant intends to use pursuant to rule 191—55.14(522C).

55.5(3) *Supplemental documentation.* The division may require the applicant for either type of license to supply any documents reasonably necessary to aid the division in making its determination.

[ARC 5250C, IAB 11/4/20, effective 12/9/20; ARC 6120C, IAB 12/29/21, effective 2/2/22]

191—55.6(522C) Public adjuster examination.

55.6(1) A resident individual applying for a public adjuster license under this chapter shall pass a written examination, unless exempt pursuant to rule 191—55.7(522C). The examination shall test the knowledge of the individual concerning the duties and responsibilities of a public adjuster and the

insurance laws and regulations of this state. Examinations required by this rule shall be conducted as prescribed by the division.

55.6(2) Each resident individual applying for an examination shall remit a nonrefundable fee as prescribed by the division and set forth in rule 191—55.20(522C).

55.6(3) A resident individual who fails to appear for the examination as scheduled or fails to pass the examination shall reapply for an examination and remit all required fees and forms before being scheduled for another examination.

55.6(4) The division may make arrangements, including contracting with an outside testing service, for administering examinations and collecting the fee set forth in rule 191—55.20(522C).

[ARC 5250C, IAB 11/4/20, effective 12/9/20]

191—55.7(522C) Exemptions from examination.

55.7(1) An individual who applies for a public adjuster license in this state who was previously licensed as a public adjuster in another state based on a public adjuster examination shall not be required to complete an examination in this state. However, an individual who moves to this state and who was previously licensed as a public adjuster in another state based on a public adjuster examination shall make application within 90 days of establishing legal residence to become a resident licensed public adjuster pursuant to rule 191—55.5(522C). No examination shall be required of that individual to obtain a public adjuster license. This exemption is available only:

a. If the individual is currently licensed in the other state or if the application is received within 12 months of the cancellation of the applicant's previous license; and

b. If the other state issues a certification that the applicant is licensed and in good standing in that state or was licensed and in good standing at the time of cancellation or if the state's producer database records, or records maintained by the NAIC, its affiliates, or subsidiaries, indicate that the public adjuster is or was licensed and in good standing.

55.7(2) An individual who applies for a public adjuster license in this state who was previously licensed as a public adjuster in this state shall not be required to complete an examination. This exemption is only available if the application is received within 12 months of the termination of the applicant's previous license in this state and if, at the time of termination, the applicant was in good standing in this state.

[ARC 5250C, IAB 11/4/20, effective 12/9/20]

191—55.8(522C) Nonresident license reciprocity.

55.8(1) Unless denied licensure pursuant to rule 191—55.12(522C), an individual or business entity for whom Iowa is not the individual's or business entity's home state, but whose home state awards nonresident public adjuster licenses to residents of Iowa on the same basis, must satisfy the following requirements to obtain an Iowa nonresident public adjuster license:

a. Be licensed as a resident public adjuster and in good standing in the individual's home state;

b. Submit a proper request for licensure to the division through the NIPR Gateway;

c. Pay the appropriate fees required, as set forth in rule 191—55.20(522C);

d. Be trustworthy, reliable, and of good reputation, evidence of which may be determined by the division; and

e. Submit to the division the contract the applicant intends to use pursuant to rule 191—55.14(522C).

55.8(2) The division may verify the public adjuster's licensing status through the producer database maintained by the NAIC, its affiliates, or subsidiaries.

55.8(3) As a condition to continuation of a public adjuster license issued under this rule, the licensed public adjuster shall maintain a resident public adjuster license in the licensed public adjuster's home state. The nonresident public adjuster license issued under this chapter shall terminate and be surrendered immediately to the division if the home state public adjuster license terminates for any reason, unless the individual has been issued a license as a resident public adjuster in the individual's new home state. The individual shall notify the state or states where nonresident public

adjuster licenses are issued as soon as possible, but no later than 30 days after the change to the new state's resident public adjuster license. The licensed public adjuster shall include both the new and the old addresses in the notice. A new state resident public adjuster license is required for the Iowa nonresident public adjuster license to remain valid. The new state resident public adjuster license must have reciprocity with Iowa as set forth in subrule 55.8(1) for the nonresident public adjuster license not to terminate. No fee or license application is required. If the new resident state is actively participating in the producer database, a letter of certification is not required. A nonresident licensed public adjuster who moves to Iowa and wishes to retain the nonresident license must file a change of address with the division within 90 days of the change of legal residence.

55.8(4) If an individual's or business entity's home state does not license public adjusters or business entity public adjusters or does not award nonresident public adjuster licenses to residents of Iowa on the same basis, the nonresident individual or business entity shall follow the procedures for obtaining a license set out in rule 191—55.5(522C).

55.8(5) The division may require an applicant to supply any documents reasonably necessary to aid the division in making its determination.

[ARC 5250C, IAB 11/4/20, effective 12/9/20; ARC 6120C, IAB 12/29/21, effective 2/2/22]

191—55.9(522C) Terms of licensure. Unless denied licensure under this chapter or under Iowa Code chapter 522C, persons who have met the requirements of this chapter and Iowa Code chapter 522C shall be issued a public adjuster license.

55.9(1) *Content of license.* The license shall contain the public adjuster's name, city and state of business address, license number, the date of issuance, the expiration date, and any other information the division deems necessary. The license number shall be the same as the public adjuster's National Insurance Producer Registry (NIPR) national producer number (NPN). The division will not send a paper license to the public adjuster, but public adjusters may download and print licenses through the division's website.

55.9(2) *Term of license.* A public adjuster license shall remain in effect for a term of two years, unless revoked, terminated or suspended, and may be continually renewed as long as the request for renewal is received, the fee set forth in rule 191—55.20(522C) is paid, and any other requirements for license renewal are met by the renewal due date. The license term shall be as follows:

a. For an individual public adjuster, the two-year-and-one-month period of time beginning on the first day of the public adjuster's birth month and ending on the last day of the public adjuster's birth month in the renewal year.

b. For a business entity public adjuster, the two-year-and-one-month period of time, including the year of application, beginning on the first day of the month of the business entity's formation date and ending on the last day of the month of the business entity's formation date. By arrangement with the division, a business entity may choose a different month for its license term.

55.9(3) *Suspension for returned payment.* If the division issues or renews a public adjuster license and subsequently determines that payment by check for the license or renewal was returned to the division by a bank without payment, or that the credit card company does not approve or cancels or refuses amounts charged to the credit card, the license shall be immediately suspended until the payments are made and any fees or penalties charged by the division are paid, at which time the license may be reinstated. The individual may request a hearing within 30 days of receipt of notice by the division that the license was suspended.

55.9(4) *Change in name, address or state of residence.*

a. Name change. If a licensed public adjuster's name is changed, the licensed public adjuster must file notification with the division within 30 days of the name change. The notification must include:

- (1) The licensed public adjuster's former name;
- (2) The licensed public adjuster's license number;
- (3) The licensed public adjuster's new name; and

(4) A copy of a legal document with proof of the name change.

b. Address change. If a licensed public adjuster's address is changed, including an email address, the licensed public adjuster must file notification with the division within 30 days of the address change. Notification may be filed through the NIPR Gateway, if available, or as instructed on the division's website. The notification must include the licensed public adjuster's:

(1) Name;

(2) License number;

(3) Previous address; and

(4) New address. A licensed public adjuster may designate a business address instead of a resident address at the option of the licensed public adjuster.

c. Change in state of residence. A nonresident licensed public adjuster who moves from one state to another state or an Iowa resident licensed public adjuster who moves to another state and wishes to retain an Iowa license must comply with subrule 55.8(3).

55.9(5) Reporting of actions.

a. A licensed public adjuster shall report to the division any administrative action taken against the licensed public adjuster in another jurisdiction or by another governmental agency in this state within 30 days of the final disposition of the matter. This report shall include a copy of the order, consent to order, or other relevant legal documents.

b. Within 30 days of the initial pretrial hearing date, a licensed public adjuster shall report to the division any criminal prosecution of the licensed public adjuster taken in any jurisdiction. The report shall include a copy of the initial complaint filed, the order resulting from the hearing, and any other relevant legal documents.

c. A licensed public adjuster shall report to the division all child support recovery unit actions taken under or in connection with Iowa Code chapter 252J and all court orders entered in such actions.

55.9(6) Failure to notify. Failure to notify the division or to file reports required by this rule is a violation of this chapter and will subject licensed public adjusters to penalty pursuant to rule 191—55.19(522C).

55.9(7) Renewal of license.

a. A person licensed as a public adjuster must apply for renewal of the license prior to the expiration date of the license.

b. Public adjuster licenses may be renewed only through the NIPR Gateway, or as otherwise directed by the division.

c. Failure to renew a license and to pay appropriate fees prior to the expiration date of the license will result in expiration of the license.

d. A resident public adjuster may reinstate an expired license up to 12 months after the license expiration date by proving that during the applicable continuing education term, the public adjuster met the continuing education requirements found in rule 191—55.11(522C) and by paying a reinstatement fee and license renewal fees, as set forth in rule 191—55.20(522C). A resident public adjuster who fails to apply for license reinstatement within 12 months of the license expiration date must apply for a new license.

e. A nonresident public adjuster may reinstate an expired license up to 12 months after the license expiration date by submitting a request to the division through the NIPR Gateway and by paying a reinstatement fee and license renewal fee. A nonresident public adjuster who fails to apply for license reinstatement within 12 months of the license expiration date or fails to update the nonresident public adjuster's address pursuant to subrule 55.9(4) must apply for a new license.

f. A licensed public adjuster that is unable to comply with license renewal procedures due to military service, a long-term medical disability, or some other extenuating circumstance may make a request to the division for a waiver of those procedures.

g. A public adjuster applying for renewal of a license shall submit to the division a copy of the contract the applicant intends to use pursuant to rule 191—55.14(522C).

55.9(8) Division functions.

a. If a licensed public adjuster has provided an email address to the division, the division has the option to send information to the licensed public adjuster through email rather than through United States mail.

b. In order to assist in the performance of the division's duties, the division may contract with nongovernmental entities, including the NAIC or any affiliates or subsidiaries that the NAIC oversees, to perform any ministerial functions that the division may deem appropriate, including the collection of fees and data related to licensing.

[ARC 4780C, IAB 11/20/19, effective 12/25/19; ARC 4848C, IAB 1/1/20, effective 2/5/20; ARC 5250C, IAB 11/4/20, effective 12/9/20; ARC 6120C, IAB 12/29/21, effective 2/2/22]

191—55.10(522C) Evidence of financial responsibility.

55.10(1) Prior to the issuance of a license as an adjuster and for the duration of the license, an applicant shall secure evidence of financial responsibility in a format prescribed by the commissioner. Evidence of financial responsibility must provide coverage for damages resulting from an adjuster's erroneous act, failure to act, fraud, acts in violation of Iowa Code chapter 522C, or unfair or deceptive act or practice as determined pursuant to Iowa Code chapter 507B. An independent contractor or an Internal Revenue Service 1099 staff adjuster must maintain the independent contractor's or the Internal Revenue Service 1099 staff adjuster's own individual bond or other qualifying financial responsibility unless specifically employed and covered by the adjuster business entity's qualifying bond or certificate of insurance. The bond or certificate of insurance must be issued by an insurer authorized to transact business in Iowa. Financial responsibility may be satisfied through one of the following options:

a. Surety bonds.

(1) Individual bond. The bond must be individually written in an amount of no less than \$50,000 and issued in favor of the state of Iowa.

(2) Business entity bond. A scheduled or blanket bond provided for an adjuster business entity employing multiple licensed adjusters with a per occurrence limit of \$50,000 and a total aggregate exposure limit in any one policy period. Bond amounts according to the number of adjusters are as follows:

Number of Adjusters	Bond Amount
2-20	\$250,000, or no less than five times the required individual bond of \$50,000
21-40	\$500,000, or no less than ten times the required individual bond of \$50,000
41 or more	\$1 million, or no less than 20 times the required individual bond of \$50,000

b. Professional liability or errors and omissions certificate of insurance. The coverage provides sufficient coverage for professional liability or acts or omissions in the performance of adjusting services for all affiliated adjusters performing activities pursuant to Iowa Code chapter 522C, individually or on behalf of the business entity, in an amount of no less than \$50,000 per adjuster and with an aggregate limit of \$1 million.

c. Irrevocable letter of credit. The irrevocable letter of credit must:

(1) Be issued by a qualified financial institution chartered under federal or state law, regulated and supervised by federal or state authorities, and authorized to transact business in the state of Iowa;

(2) Be in the minimum amount of \$50,000;

(3) Be subject to lawful levy of execution on behalf of any person to whom the adjuster has been found to be legally liable as the result of an adjuster's erroneous act, failure to act, fraud, acts in violation of Iowa Code chapter 522C, or unfair or deceptive act or practice as determined pursuant to Iowa Code chapter 507B; and

(4) Provide written notice of termination to the licensee at least 30 days prior to termination.

55.10(2) The division may request evidence of financial responsibility at any time the division deems relevant.

55.10(3) An adjuster shall immediately notify the division if evidence of financial responsibility terminates or becomes impaired. The authority to act as an adjuster shall automatically terminate if the evidence of financial responsibility terminates or becomes impaired.

This rule is intended to implement Iowa Code chapter 522C.

[ARC 0308D, IAB 5/27/26, effective 5/5/26]

191—55.11(522C) Continuing education.

55.11(1) An individual who holds a public adjuster license shall satisfactorily complete a minimum of 24 credits of continuing education, including 2 credits of ethics, reported on a biennial basis in conjunction with the license renewal cycle. "Credit" means 50 minutes of instruction or reading material in an acceptable topic of continuing education.

55.11(2) This rule shall not apply to a licensed public adjuster holding a nonresident public adjuster license who has met the continuing education requirements of the adjuster's home state and whose home state gives credit to residents of this state on the same basis.

55.11(3) Only continuing education courses approved by the division pursuant to 191—Chapter 11, substituting "public adjuster" for "insurance producer," shall be used to satisfy the continuing education requirement of subrule 55.11(1).

[ARC 5250C, IAB 11/4/20, effective 12/9/20]

191—55.12(522C) License denial, nonrenewal or revocation.

55.12(1) The commissioner may place on probation, suspend, revoke or refuse to issue or renew a public adjuster's license; may levy a civil penalty in accordance with Iowa Code section 505.7A; or may take corrective action pursuant to Iowa Code section 505.8, or any combination of actions, for any one or more of the following causes:

a. Providing incorrect, misleading, incomplete, or materially untrue information in the license application;

b. Failing to complete continuing education as required by rule 191—55.11(522C);

c. Violating any insurance laws, or violating any regulation, subpoena, or order of the commissioner or of another state's insurance commissioner;

d. Obtaining or attempting to obtain a license through misrepresentation or fraud;

e. Improperly withholding, misappropriating, or converting any moneys or properties received in the course of doing adjuster business;

f. Intentionally misrepresenting the terms of an insurance contract;

g. Having been convicted of a felony;

h. Having admitted to or having been found to have committed any insurance unfair trade practice or insurance fraud;

i. Using fraudulent, coercive or dishonest practices; or demonstrating incompetence, untrustworthiness or financial irresponsibility in the conduct of business in this state or elsewhere;

j. Having an insurance license or a public adjuster license, or the equivalent, denied, suspended, or revoked in any other state, province, district or territory;

k. Cheating, including improperly using notes or any other reference material, to complete an examination for any adjuster license;

l. Failing to comply with an administrative or court order imposing a child support obligation, following procedures of rule 191—10.21(252J,272D), replacing the word "producer" with "public adjuster";

m. Failing to pay state income tax or to comply with any administrative or court order directing payment of state income tax, following procedures of rule 191—10.21(252J,272D), replacing the word “producer” with “public adjuster”;

n. Misrepresenting to a claimant that the public adjuster is an adjuster representing an insurer in any capacity, including acting as an employee of the insurer or acting as an independent adjuster, unless so appointed by an insurer in writing to act on the insurer’s behalf for that specific claim or purpose. A licensed public adjuster is prohibited from charging that specific claimant a fee when the public adjuster is appointed by the insurer and the appointment is accepted by the public adjuster;

o. Failing to maintain evidence of financial responsibility as required by rule 191—55.10(522C);

p. For a business entity licensed as a public adjuster, failing to designate only licensed individual public adjusters to exercise the business of the business entity’s license;

q. Failing to report to the division any notifications or actions required to be reported pursuant to rule 191—55.9(522C);

r. Failing to file reports required by this chapter; or

s. Failing or refusing to cooperate in an investigation by the division.

55.12(2) In the event that the action by the commissioner is to deny an application for or not to renew a license, the commissioner shall notify the applicant or licensed public adjuster and advise, in writing, the applicant or licensed public adjuster of the reason for the nonrenewal or denial of the applicant’s or licensed public adjuster’s license. The applicant or licensed public adjuster may request a hearing pursuant to 191—Chapter 3 and Iowa Code chapter 17A.

55.12(3) The license of a business entity may be suspended, revoked or refused if the commissioner finds, after hearing, that an individual licensed public adjuster’s violation was known or should have been known by one or more of the partners, officers or managers acting on behalf of the business entity and the violation was neither reported to the commissioner nor corrective action taken.

55.12(4) In addition to or in lieu of any applicable denial, suspension or revocation of a license, a person may, after hearing, be subject to a civil fine pursuant to Iowa Code section 505.7A, or to other corrective action pursuant to Iowa Code section 505.8.

55.12(5) The commissioner shall retain the authority to enforce the provisions of and impose any penalty or remedy authorized by this chapter and Iowa Code chapters 505 and 522C against any person who is under investigation for or charged with a violation of this chapter and Iowa Code chapter 522C, even if the person’s license has been surrendered or has lapsed by operation of law.

[ARC 4848C, IAB 1/1/20, effective 2/5/20; ARC 5250C, IAB 11/4/20, effective 12/9/20; ARC 6120C, IAB 12/29/21, effective 2/2/22]

191—55.13(522C) Reinstatement or reissuance of a license after suspension, revocation or forfeiture in connection with disciplinary matters; and forfeiture in lieu of compliance.

55.13(1) *Definitions and scope.*

a. The term “reinstatement” as used in this rule means the reinstatement of a suspended license.

b. The term “reissuance” as used in this rule means the issuance of a new license following the revocation of a license, the suspension and subsequent termination of a license, or the forfeiture of a license in connection with a disciplinary matter.

c. This rule does not apply to the reinstatement of an expired license that is not in connection with a disciplinary matter.

55.13(2) *Application required.* Any person licensed in Iowa as a public adjuster whose license has been revoked or suspended by order, or who forfeited a license in connection with a disciplinary matter, may apply to the commissioner for reinstatement or reissuance in accordance with the terms of the order of revocation or suspension or the order accepting the forfeiture.

a. All proceedings for reinstatement or reissuance shall be initiated by the applicant who shall file with the commissioner an application for reinstatement or reissuance of a license. As part of

the application, the applicant shall submit to a criminal history check pursuant to Iowa Code section 522B.5A.

b. An application for reinstatement or reissuance shall allege facts which, if established, will be sufficient to enable the commissioner to determine that the basis of revocation, suspension or forfeiture of the applicant's license no longer exists and that it will be in the public interest for the application to be granted. The burden of proof to establish such facts shall be on the applicant.

c. A person licensed as a public adjuster may request reinstatement of a suspended license prior to the end of the suspension term.

d. Unless otherwise provided by law, if the order of revocation or suspension did not establish terms upon which reinstatement or reissuance may occur, or if the license was forfeited, an initial application for reinstatement or reissuance may not be made until at least one year has elapsed from the date of the order of the suspension (notwithstanding paragraph 55.13(2) "c"), revocation, or acceptance of the forfeiture of a license.

55.13(3) *Proceedings.* All proceedings upon the application for reinstatement or reissuance, including matters preliminary and ancillary thereto, shall be held in accordance with Iowa Code chapter 17A. Such application shall be docketed in the original case in which the original license was suspended, revoked, or forfeited, if a case exists.

55.13(4) *Order.* An order of reinstatement or reissuance shall be based upon a written decision which incorporates findings of fact and conclusions of law. An order granting an application for reinstatement or reissuance may impose such terms and conditions as the commissioner or the commissioner's designee deems desirable, which may include one or more of the types of disciplinary sanctions provided by this chapter and Iowa Code chapter 522C. The order shall be a public record, available to the public, and may be disseminated in accordance with Iowa Code chapters 22 and 505.

55.13(5) *Suspension in relation to expiration date.* When a public adjuster's license has been suspended for a period of time which extends beyond the public adjuster's license expiration date, the license will terminate at the license expiration date and the public adjuster must request reinstatement pursuant to subrule 55.10(2). If suspension for a period of time ends prior to the public adjuster's license expiration date and the public adjuster has met all applicable requirements, the division shall reinstate the license as soon as practicable but no earlier than the end of the suspension period. The commissioner is not prohibited from denying reinstatement or bringing an additional immediate action if the public adjuster has engaged in misconduct during the period of suspension.

55.13(6) *Voluntary forfeiture.* A submission of voluntary forfeiture of a license shall be made in writing to the commissioner. Forfeiture of a license is effective upon submission unless a contested case proceeding is pending at the time of submission. If a contested case proceeding is pending, the forfeiture shall become effective when and upon such conditions as required by order of the commissioner. A forfeiture made during the pendency of a contested case proceeding is considered disciplinary action and shall be published in the same manner as is applicable to any other form of disciplinary order.

55.13(7) *Forfeiture in lieu of compliance.* A license may be voluntarily forfeited in lieu of compliance with an order of the commissioner or the commissioner's designee with the written consent of the commissioner. The forfeiture shall become effective when and upon such conditions as required by order of the commissioner, which may include one or more of the types of disciplinary sanctions provided by this chapter and Iowa Code chapter 522C.

[ARC 5250C, IAB 11/4/20, effective 12/9/20]

191—55.14(522C) Contract between public adjuster and insured.

55.14(1) Public adjusters shall ensure that all contracts for their services are in writing and contain the following terms:

- a.* Name and address of the public adjuster negotiating the contract and, if applicable, the name, address, and license number of the business entity with which the public adjuster is associated;
- b.* Permanent home state business address and telephone number;

- c. Public adjuster license number;
- d. Title of "Public Adjuster Contract";
- e. Insured's full name, street address, insurance company name and policy number, if known or upon notification;
- f. Description of the loss and its location, if applicable;
- g. Description of services to be provided to the insured;
- h. Signatures of the public adjuster and the insured;
- i. Date contract was signed by the public adjuster and date the contract was signed by the insured;
- j. Attestation language stating that the public adjuster is fully bonded pursuant to state law; and
- k. Compensation the public adjuster is to receive for services, whether it be an hourly rate, flat fee, percentage of settlement, or some other method of compensation, and a detailed explanation of how the amount is to be specifically calculated based on the services provided by the public adjuster.

55.14(2) The contract may specify that the public adjuster shall be named as a co-payee on an insurer's payment of a claim.

a. If the compensation is based on a share of the insurance settlement, the exact percentage shall be specified.

b. Initial expenses to be reimbursed to the public adjuster from the proceeds of the claim payment shall be specified by type, with dollar estimates set forth in the contract. Any additional expenses shall be approved by the insured.

c. Compensation provisions in a public adjusting contract shall not be redacted in any copy of the contract provided to the division. Such a redaction shall constitute a dishonest practice in violation of paragraph 55.12(1) "i."

55.14(3) If the insurer, not later than 72 hours after the date on which the loss is reported to the insurer, either pays or commits in writing to pay to the insured the policy limit of the insurance policy, the public adjuster shall:

a. Not receive a commission consisting of a percentage of the total amount paid by an insurer to resolve a claim;

b. Inform the insured that the loss recovery amount might not be increased by the insurer; and

c. Be entitled only to reasonable compensation from the insured for services provided by the public adjuster on behalf of the insured, based on the time spent on a claim and expenses incurred by the public adjuster, until the claim is paid or the insured receives a written commitment to pay from the insurer.

55.14(4) A public adjuster shall provide the insured a written disclosure concerning any direct or indirect financial interest that the public adjuster has with any other party who is involved in any aspect of the claim, other than the salary, fee, commission or other consideration established in the written contract with the insured, including but not limited to any ownership of, other than as a minority stockholder, or any compensation expected to be received from, any construction firm, salvage firm, building appraisal firm, motor vehicle repair shop, or any other firm that provides estimates for work, or that performs any work, in conjunction with damage caused by the insured loss on which the public adjuster is engaged. The term "firm" shall include any corporation, partnership, association, joint-stock company or person.

55.14(5) A public adjuster contract may not contain any contract term that:

a. Allows the public adjuster's percentage fee to be collected when money is due from an insurance company, but not paid, or that allows a public adjuster to collect the entire fee from the first check issued by an insurance company, rather than as a percentage of each check issued by an insurance company;

b. Requires the insured to authorize an insurance company to issue a check only in the name of the public adjuster;

c. Imposes collection costs or late fees;

d. Precludes a public adjuster from pursuing civil remedies; or

e. Restricts an insured's right to initiate and maintain direct communications with the insured's attorney, the insurer, the insurer's adjuster, the insurer's attorney, or any other person regarding settlement of the insured's claim.

55.14(6) Prior to the signing of the contract, the public adjuster shall provide the insured with a separate disclosure document regarding the claim process as set forth in Appendix I.

55.14(7) The contract shall be executed in duplicate to provide an original contract to the public adjuster and an original contract to the insured. The public adjuster's original contract shall be available at all times for inspection without notice by the division.

55.14(8) The public adjuster shall provide the insurer a notification letter, which has been signed by the insured, authorizing the public adjuster to represent the insured's interest.

55.14(9) The public adjuster shall give the insured written notice of the insured's rights as provided in Iowa Code chapter 555A, and the insured may rescind the contract as provided in Iowa Code chapter 555A. The contract shall not be construed to prevent an insured from pursuing any civil remedy after the three-business-day revocation or cancellation period.

55.14(10) If the insured exercises the right to rescind the contract, anything of value given by the insured under the contract will be returned to the insured within 15 business days following the receipt by the public adjuster of the cancellation notice.

[ARC 5250C, IAB 11/4/20, effective 12/9/20; ARC 6120C, IAB 12/29/21, effective 2/2/22]

191—55.15(522C) Escrow accounts. A public adjuster who receives, accepts or holds, on behalf of an insured, any funds toward the settlement of a claim for loss or damage shall deposit the funds in a non-interest-bearing escrow or trust account in a financial institution that is insured by an agency of the federal government in the public adjuster's home state or where the loss occurred.

[ARC 5250C, IAB 11/4/20, effective 12/9/20; ARC 6120C, IAB 12/29/21, effective 2/2/22]

191—55.16(522C) Record retention.

55.16(1) A public adjuster shall maintain a complete record of each transaction as a public adjuster. The records required by this rule shall include the following:

- a.* The name of the insured;
- b.* The date, location and amount of the loss;
- c.* A copy of the contract between the public adjuster and the insured;
- d.* The name of the insurer, amount, expiration date and number of each policy carried with respect to the loss;
- e.* An itemized statement of the insured's recoveries;
- f.* An itemized statement of all compensation received by the public adjuster, from any source whatsoever, in connection with the loss;
- g.* A register of all moneys received, deposited, disbursed, or withdrawn in connection with a transaction with an insured, including fees, transfers and disbursements from a trust account and all transactions concerning all interest-bearing accounts;
- h.* The name of the public adjuster who executed the contract;
- i.* The name of the attorney representing the insured, if applicable, and the name of the claims representative of the insurance company;
- j.* Evidence of financial responsibility in a format prescribed by the insurance division; and
- k.* All records related to the authorization and notice requirements of subrule 55.17(14).

55.16(2) Records shall be maintained for at least five years after the termination of the transaction with an insured and shall be open to examination by the division at all times.

55.16(3) Records submitted to the division in accordance with this rule that contain information identified in writing as proprietary by the public adjuster shall be treated as confidential by the division and shall not be subject to Iowa Code chapter 22.

[ARC 5250C, IAB 11/4/20, effective 12/9/20; ARC 6120C, IAB 12/29/21, effective 2/2/22]

191—55.17(522C) Standards of conduct of public adjuster.

55.17(1) A public adjuster shall serve with objectivity and complete loyalty the interest of the insured and shall render to the insured in good faith such information, counsel and service, as within the knowledge, understanding and opinion of the licensed public adjuster, as will best serve the insured's insurance claim needs and interest.

55.17(2) A public adjuster shall not solicit, or attempt to solicit, an insured during the progress of a loss-producing occurrence, as defined in the insured's insurance contract.

55.17(3) A public adjuster shall not permit an unlicensed employee or representative of the public adjuster to conduct business for which a license is required under this chapter or Iowa Code chapter 522C.

55.17(4) A public adjuster shall not have a direct or indirect financial interest in any aspect of the claim, other than the salary, fee, commission or other consideration established in the written contract with the insured, unless full written disclosure has been made to the insured as set forth in subrule 55.14(4).

55.17(5) A public adjuster shall not acquire any interest in salvage of property subject to the contract with the insured unless the public adjuster obtains written permission from the insured after settlement of the claim with the insurer as set forth in subrule 55.14(4).

55.17(6) The public adjuster shall abstain from referring or directing the insured to obtain needed repairs or services in connection with a loss from any person, unless disclosed to the insured:

- a. With whom the public adjuster has a financial interest; or
- b. From whom the public adjuster may receive direct or indirect compensation for the referral.

55.17(7) Licensed public adjusters may not solicit an insured for employment between the hours of 8 p.m. and 9 a.m.

55.17(8) Any compensation or anything of value in connection with an insured's specific loss that will be received by a public adjuster shall be disclosed by the public adjuster to the insured in writing, including the source and amount of any such compensation.

55.17(9) A public adjuster shall not undertake the adjustment of any claim if the public adjuster is not competent and knowledgeable as to the terms and conditions of the insurance coverage, or if the loss or coverage otherwise exceeds the public adjuster's current expertise.

55.17(10) A public adjuster shall not knowingly make any false oral or written material statements regarding any person engaged in the business of insurance to any insured or potential insured.

55.17(11) No public adjuster, while so licensed by the division, may represent or act as a company adjuster or independent adjuster in any circumstance.

55.17(12) A public adjuster shall not enter into a contract or accept a power of attorney that vests in the public adjuster the effective authority to choose the persons who shall perform repair work.

55.17(13) A public adjuster may not agree to any loss settlement without the insured's knowledge and consent.

55.17(14) Authorization and notice of claim payments.

a. If the public adjuster and the insured contract for the public adjuster to be named as a co-payee on any claim payments issued by the insurance company, the public adjuster shall obtain written authorization from the insured in order for the public adjuster to sign or endorse a payment, draft, or check on behalf of an insured.

b. The authorization can be withdrawn by the insured at any time upon written notice to the public adjuster. Authorization and notice may be given and received through electronic means in compliance with Iowa Code section 554D.110. All records of authorization and notice must be maintained by the public adjuster in compliance with rule 191—55.16(522C).

c. If the public adjuster is granted authorization and receives a check, the public adjuster must do the following:

(1) Endorse the check or payment for deposit only into the public adjuster's non-interest-bearing escrow or trust account; and

(2) Notify the insured of the deposit of funds no later than five business days after receipt by the public adjuster.

[ARC 5250C, IAB 11/4/20, effective 12/9/20; ARC 6120C, IAB 12/29/21, effective 2/2/22]

191—55.18(522C) Public adjuster fees.

55.18(1) A public adjuster may charge the insured a reasonable fee for public adjuster services.

55.18(2) A person shall not accept a commission, service fee or other valuable consideration for investigating or settling claims in this state if that person is required to be licensed under this chapter and is not so licensed.

55.18(3) In the event of a catastrophic disaster, there shall be limits on catastrophic fees. No public adjuster shall charge, agree to or accept as compensation or reimbursement any payment, commission, fee, or other thing of value equal to or more than 10 percent of any insurance settlement or proceeds. No public adjuster shall require, demand or accept any fee, retainer, compensation, deposit, or other thing of value, prior to settlement of a claim, unless the loss is being handled by the public adjuster on a time-plus-expense basis.

[ARC 5250C, IAB 11/4/20, effective 12/9/20]

191—55.19(522C) Penalties. Failure to comply with this chapter or with Iowa Code chapter 522C shall subject a person to penalties set forth in Iowa Code section 522C.6.

[ARC 5250C, IAB 11/4/20, effective 12/9/20]

191—55.20(522C) Fees.

55.20(1) Fees may be paid by check or credit card.

55.20(2) The fee for a criminal history check as required pursuant to Iowa Code section 522B.5A is \$50.

55.20(3) The fee for issuance or renewal of an individual public adjuster license is \$50 for two years.

55.20(4) The fee for issuance or renewal of a business entity public adjuster license is \$50 for two years.

55.20(5) The fee for reinstatement of a public adjuster license is \$50.

55.20(6) The division may charge a reasonable fee for the compilation and production of public adjuster licensing records.

55.20(7) The fee for an examination may be set by the outside testing service under contract with the division and must be approved by the division.

[ARC 5250C, IAB 11/4/20, effective 12/9/20; ARC 6547C, IAB 10/5/22, effective 11/9/22]

191—55.21(522C) Severability. If any rule or portion of a rule of this chapter, or its applicability to any person or circumstances, is held invalid by a court, the remainder of this chapter, or the applicability or its provisions to other persons, shall not be affected.

[ARC 5250C, IAB 11/4/20, effective 12/9/20]

These rules are intended to implement Iowa Code chapter 522C.

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[Filed Emergency ARC 0308D, IAB 5/27/26, effective 5/5/26]

APPENDIX I
DISCLOSURE DOCUMENT
REGARDING THE CLAIM PROCESS

(1) Property insurance policies obligate the insured to present a claim to the insured's insurance company for consideration. There are three types of adjusters that could be involved in that process. The definitions of the three types are as follows:

(a) "Company adjusters" means the insurance adjusters who are employees of insurance companies. They represent the interests of the insurance companies and are paid by the insurance companies. They will not charge the insureds fees.

(b) "Independent adjusters" means the insurance adjusters who are hired on a contract basis by insurance companies to represent the insurance companies' interests in the settlement of claims. They are paid by the insurance companies. They will not charge the insureds fees.

(c) "Public adjusters" means the insurance adjusters who do not work for any insurance companies. They work for insureds to assist in the preparation, presentation and settlement of claims. The insureds hire them by signing contracts agreeing to pay them fees or commissions based on a percentage of the settlements, or other method of compensation.

(2) The insured is not required to hire a public adjuster to help the insured meet the insured's obligations under the policy, but has the right to do so.

(3) The insured has the right to initiate direct communications with the insured's attorney, the insurer, the insurer's adjuster, the insurer's attorney or any other person regarding the settlement of the insured's claim.

(4) The public adjuster is not a representative or employee of the insurer.

(5) The salary, fee, commission or other consideration is the obligation of the insured, not the insurer.

(6) An insured may contact the Iowa Insurance Division with questions about insurance law toll-free from within Iowa at (877)955-1212 or through the Division's website at iid.iowa.gov.

ECONOMIC DEVELOPMENT AUTHORITY[261]

[Created by 1986 Iowa Acts, chapter 1245]

[Prior to 1/14/87, see Iowa Development Commission[520] and Planning and Programming[630]]

[Prior to 9/7/11, see Economic Development, Iowa Department of[261];
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Chapter rescission date pursuant to Iowa Code section 17A.7: 7/1/31

261—403.1(15) Definitions. As used in these rules, unless the context otherwise requires:

“*Authority*” means the economic development authority created in Iowa Code section 15.105.

“*Board*” means the governing board of the Iowa energy center established pursuant to Iowa Code section 15.120(2) and includes the members appointed to the board by the governor.

“*Committee*” means a committee established by the board.

“*Iowa energy center*” or “*IEC*” means the Iowa energy center established pursuant to Iowa Code section 15.120 for the purposes identified therein.

[ARC 0309D, IAB 5/27/26, effective 7/1/26]

261—403.2(15) Iowa energy center board.

403.2(1) *Quorum and voting requirements.* Seven or more members of the board constitute a quorum, and any board action requires an affirmative vote by a majority of the members present.

403.2(2) *Board officers.* Members of the board elect a chairperson and a vice chairperson annually and may elect other officers as necessary.

403.2(3) *Meetings.*

a. The board generally meets quarterly at the authority’s offices or by electronic means. By notice of the regularly published meeting agendas, the board and its committees may hold regular or special meetings at other locations within the state. Meeting agendas are available on the authority’s website at www.opportunityiowa.gov.

b. The chairperson may exclude any person disrupting the proceedings.

403.2(4) *Committees.* The board may, from time to time, establish advisory committees for purposes of overseeing the IEC, its programs, and its operations. Such committees include but are not limited to the following:

a. A grant committee is established to assist the board in making and administering awards of grants under the IEC’s programs.

(1) The grant committee is an advisory body comprised of voting members of the board who are selected annually by the voting members of the board. The membership and size of the committee as well as the terms of the committee members will be established annually by the board.

(2) The members of the grant committee may elect a chairperson. The chairperson may appoint members of the grant committee to serve on a grant committee subcommittee if necessary. Such a subcommittee is advisory only and may perform such duties as may be assigned by the chairperson.

(3) The duties of the grant committee may include reviewing applications for grant awards, making recommendations to the board regarding the size and condition of grant awards, and any other duty assigned by the board in relation to the programs administered by the IEC.

(4) A majority of the committee members constitutes a quorum of the committee.

(5) Meetings of the grant committee are held at the call of the chairperson.

b. A loan committee is established to assist the board in making and administering loan awards under the IEC’s programs, including the alternate energy revolving loan program and energy infrastructure revolving loan program.

(1) The loan committee is an advisory body comprised of voting members of the board who are selected annually by the voting members of the board. The membership and size of the committee as well as the terms of the committee members will be established annually by the board.

(2) The members of the loan committee may elect a chairperson. The chairperson may appoint members of the loan committee to serve on a loan committee subcommittee if necessary. Such a subcommittee is advisory only and may perform such duties as may be assigned by the chairperson.

(3) The duties of the loan committee may include reviewing applications for loans, making recommendations to the board regarding the size and condition of loans, and any other duty assigned by the board in relation to the programs administered by the IEC.

(4) A majority of the committee members constitutes a quorum of the committee.

(5) Meetings of the loan committee are held at the call of the chairperson.

[ARC 0309D, IAB 5/27/26, effective 7/1/26]

These rules are intended to implement Iowa Code section 15.120.

[Filed ARC 4063C (Notice ARC 3842C, IAB 6/20/18), IAB 10/10/18, effective 11/14/18]

[Filed Emergency After Notice ARC 5994C (Notice ARC 5878C, IAB 8/25/21), IAB 10/20/21,
effective 9/30/21]

[Filed ARC 6492C (Notice ARC 6383C, IAB 6/29/22), IAB 9/7/22, effective 10/12/22]

[Filed ARC 0309D (Notice ARC 9951C, IAB 1/7/26), IAB 5/27/26, effective 7/1/26]

CHAPTER 405
ALTERNATE ENERGY REVOLVING LOAN PROGRAM

Chapter rescission date pursuant to Iowa Code section 17A.7: 7/1/31

261—405.1(15) Definitions.

“Alternate energy production facility” means the same as defined in Iowa Code section 476.42.

“Authority” means the economic development authority created in Iowa Code section 15.105.

“Board” means the governing board of the Iowa energy center established pursuant to Iowa Code section 15.120(2).

“Iowa energy center” or *“IEC”* means the Iowa energy center established by Iowa Code section 15.120.

“Project” means the construction of an alternate energy production facility or a small hydro facility.

“Small hydro facility” means the same as defined in Iowa Code section 476.42.

[ARC 0310D, IAB 5/27/26, effective 7/1/26]

261—405.2(15) Loan amounts and terms.

405.2(1) The minimum loan amount is \$25,000 per project, and the maximum loan amount shall not exceed the amount set forth in Iowa Code section 476.46(2) “d.”

405.2(2) The board shall not lend more than 50 percent of eligible project costs.

405.2(3) Loan terms will be consistent with Iowa Code section 476.46(2) “e.”

405.2(4) A borrower shall be eligible for not more than \$1 million in loans outstanding at any time under this program.

405.2(5) The board shall not issue a loan that exceeds the value of the collateral provided.

405.2(6) The board will accept security for a loan. The following forms of collateral will be accepted:

- a. Real property;
- b. Dedicated certificate of deposit;
- c. Irrevocable letter of credit;
- d. Corporate guarantee;
- e. Other forms of collateral if approved by the board and only if the forms of collateral listed in paragraphs 405.2(6) “a” through “d” are inadequate.

405.2(7) Term. The duration of the loan shall be for 20 years, the estimated useful life of the project that is financed by the loan, the terms of any other loans used to finance the project, or the estimated return on investment time period for the project, whichever is shortest.

[ARC 0310D, IAB 5/27/26, effective 7/1/26]

261—405.3(15) Borrowers.

405.3(1) *Eligible borrowers.* The project shall be wholly owned by an eligible borrower. Eligible borrowers include:

- a. Persons whose primary residence is in Iowa.
- b. Businesses registered and domiciled in Iowa. For businesses organized as limited liability companies, each member of the limited liability company must be domiciled in Iowa and be an eligible borrower.
- c. Water and wastewater utilities subject to Iowa Code chapter 388, rural water districts subject to Iowa Code chapters 357A and 504, and sanitary districts subject to Iowa Code chapter 358.

405.3(2) *Ineligible borrowers.* Ineligible borrowers include:

- a. An organization that is lending to a project and also owns the project or is a member of an organization that owns the project.
- b. An individual or an organization with a history of defaulted loans or compliance violations with other state programs or rules.

- c. Regents institutions.
- d. Community colleges.
- e. State agencies.
- f. Cities, but not water or wastewater utilities subject to Iowa Code chapter 388.
- g. Counties.
- h. School districts.
- i. Nonprofit organizations.
- j. Gas and electric utilities subject to Iowa Code chapter 388 or rural electric cooperatives subject to Iowa Code chapter 476.

[ARC 0310D, IAB 5/27/26, effective 7/1/26]

261—405.4(15) Administration.

405.4(1) Amendment. Any substantive change to a project shall require an amendment to the loan agreement. The borrower shall request the amendment in writing. No substantive amendment shall be valid until approved by the board. The authority may execute nonsubstantive or corrective changes to the loan agreement without board approval.

405.4(2) Closeout. Upon project completion, the authority will initiate project closeout procedures.

405.4(3) Recordkeeping and retention. Borrowers shall retain all financial records, all supporting documents, and all other records pertinent to the loan for five years after the loan agreement is closed or the date the authority issues a written notice of default if the default is not cured.

405.4(4) Reporting and compliance. The authority reserves the right to conduct a site visit of all awarded projects to ensure the projects were built as proposed and to provide verification of ongoing operation. The authority will monitor all loans to ensure that loan proceeds have been spent as identified in the contract and that all other sources of financing have been committed to the project. Borrowers shall be required to notify the authority of any change in ownership.

405.4(5) Default.

a. At any time during the construction of a project or the repayment of the loan, the authority may find that a borrower is in default under the terms of the loan agreement. The authority will take prompt, appropriate, and aggressive debt collection action to recover any funds misspent by borrowers.

b. If the authority determines that a borrower is in default, the authority may seek recovery of the loan plus interest or other penalties as authorized pursuant to Iowa Code section 476.46, negotiate alternative payment schedules, suspend or discontinue collection efforts, and take other action as the authority deems necessary.

c. The authority shall attempt to collect the amount owed. Any negotiated settlement, write-off, or discontinuance of collection efforts is subject to final review by and approval of the board.

d. If the authority refers a defaulted loan to outside counsel for debt collection, then the terms of the contract between the authority and the outside counsel regarding the scope of counsel's authorization to accept settlements shall apply.

[ARC 0310D, IAB 5/27/26, effective 7/1/26]

261—405.5(15) Applicability after June 30, 2021. To the extent allowed by other provisions of law, the rules adopted in this chapter shall continue to apply to agreements entered into on or before June 30, 2021.

[ARC 0310D, IAB 5/27/26, effective 7/1/26]

These rules are intended to implement Iowa Code sections 15.120 and 476.46.

[Filed ARC 4263C (Notice ARC 4148C, IAB 12/5/18), IAB 1/30/19, effective 3/6/19]

[Filed Emergency After Notice ARC 5994C (Notice ARC 5878C, IAB 8/25/21), IAB 10/20/21, effective 9/30/21]

[Filed ARC 0310D (Notice ARC 9950C, IAB 1/7/26), IAB 5/27/26, effective 7/1/26]

CHAPTER 406
ENERGY INFRASTRUCTURE REVOLVING LOAN PROGRAM

Chapter rescission date pursuant to Iowa Code section 17A.7: 7/1/31

261—406.1(15,476) Definitions.

“Affiliates” means any entity that directly or indirectly, through one or more intermediaries controls, is controlled by, or is under common control with another entity or person. “Control” as used in this definition means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of an enterprise through ownership, by contract, or otherwise. A voting interest of 10 percent or more creates a rebuttable presumption of control.

“Authority” means the economic development authority created in Iowa Code section 15.105.

“Board” means the governing board of the Iowa energy center established pursuant to Iowa Code section 15.120(2).

“Borrower” means an applicant for the program that is approved for a loan.

“Energy infrastructure” means the same as defined in Iowa Code section 476.46A(3)“a.”

“Iowa energy center” or *“IEC”* means the Iowa energy center established by Iowa Code section 15.120.

“Loan” means an award of assistance with the requirement that the award be repaid with term, interest rate, and other conditions specified as part of the conditions of the award.

“Loan committee” means the committee of the board established to review loan applications pursuant to 261—Chapter 403.

“Program” means the energy infrastructure revolving loan program administered pursuant to Iowa Code section 476.46A and this chapter.

“Project” means an activity or set of activities, proposed in an application by a borrower, that are designed to accomplish the energy infrastructure goals of the program.

[ARC 0311D, IAB 5/27/26, effective 7/1/26]

261—406.2(15,476) Loan amounts and terms.

406.2(1) The minimum loan amount is \$50,000 per project.

406.2(2) The board shall not lend more than 75 percent of total project costs for any project type. For purposes of determining the amount the board may lend pursuant to this subrule, total project costs include eligible costs pursuant to subrule 406.5(1) as well as other costs determined by the board to be necessary to the development of energy infrastructure.

406.2(3) The board shall not issue a loan that exceeds the value of the collateral provided.

406.2(4) The board will accept security for a loan. The following forms of collateral will be accepted:

- a. Real property.
- b. Dedicated certificate of deposit.
- c. Irrevocable letter of credit.
- d. Corporate guarantee.
- e. Utility revenue or reserve funds, if applicable.
- f. Other forms of collateral if approved by the board and only if the forms of collateral listed in paragraphs 406.2(4)“a” through “e” are inadequate.

406.2(5) The board may consider the borrower’s credit rating in determining what form of collateral is acceptable.

406.2(6) The board may consider the projected payback date of the project in determining the duration of the loan, which shall not exceed 15 years.

406.2(7) The interest rate shall not exceed the Wall Street Journal prime rate as of the date of approval.

[ARC 0311D, IAB 5/27/26, effective 7/1/26]

261—406.3(15,476) Eligible and ineligible borrowers.

406.3(1) *Eligible borrowers.* Iowa Code section 476.46A(2) describes the entities eligible for financial assistance under this program.

406.3(2) *Ineligible borrowers.* Ineligible borrowers include:

- a. A business that is not located in or operating in Iowa. A business that will be located and operating in Iowa upon completion of an eligible project may be eligible.
- b. An individual or an organization with a history of defaulted loans or compliance violations with other state programs or rules.
- c. Regents institutions.
- d. Community colleges.
- e. State agencies.
- f. Cities, except municipal utilities that are eligible borrowers pursuant to Iowa Code section 476.46A(2).
- g. Counties.
- h. School districts.
- i. Nonprofit organizations.

[ARC 0311D, IAB 5/27/26, effective 7/1/26]

261—406.4(15,476) Eligible and ineligible projects.

406.4(1) Only projects meeting the following criteria are eligible for a loan under this program:

- a. The project shall be located in Iowa or be for the primary use or benefit of Iowans. If any portion of the project is located outside of Iowa, the applicant bears the burden of demonstrating that the project as a whole will be for the primary use or benefit of Iowans.
- b. The project shall develop and construct energy infrastructure pursuant to Iowa Code section 476.46A(3) “a.”
- c. The borrower shall be the owner, contract purchaser, lessee, or other interest holder of the real property where the project is located.

406.4(2) A project that generates energy for use only at a borrower’s personal residence is not an eligible project.

[ARC 0311D, IAB 5/27/26, effective 7/1/26]

261—406.5(15,476) Eligible and ineligible costs.

406.5(1) *Eligible costs.* Examples of project costs that are eligible for financial assistance include but are not limited to:

- a. Real and personal property comprising a project.
- b. Materials and equipment required for necessary site preparation, construction, and installation.
- c. Labor for site preparation, construction, and installation of a project.
- d. Costs associated with maintenance, operation, or repair of a project during the term of the loan.

406.5(2) *Ineligible costs.* Examples of project costs that are not eligible for financial assistance include but are not limited to:

- a. Administrative costs or employee salaries of the borrower or any affiliates that are not associated with site preparation, construction, and installation of a project.
- b. Costs incurred prior to the committee’s recommendation to approve a loan. Costs incurred prior to the committee’s recommendation may be eligible for assistance if the borrower demonstrates the necessity to begin incurring costs sooner.
- c. Permitting or regulatory costs.
- d. Other costs that the board determines to be ineligible.

[ARC 0311D, IAB 5/27/26, effective 7/1/26]

261—406.6(15,476) Application process.

406.6(1) Application forms are available at iowagrants.gov.

406.6(2) Applications will be accepted only during the established application periods identified by the authority on its website at www.opportunityiowa.gov.

406.6(3) The authority will review applications for completeness, eligibility, and technical and financial merit. The authority may engage outside reviewers to complete technical, financial, or other reviews of applications as needed. The authority may request additional information from applicants to complete review of applications.

406.6(4) The authority will prepare recommendations for the loan committee. The loan committee will review the applications and staff recommendations and then make recommendations to the board. The board will approve, defer, or deny applications for loans. The authority may negotiate the amount, terms, and other conditions of each loan before an award is approved.

[ARC 0311D, IAB 5/27/26, effective 7/1/26]

261—406.7(15,476) Administration.

406.7(1) *Notice of approval or denial.* The authority will notify applicants in writing of the board's approval or denial of an application. If the application is approved, the notice will include any conditions and terms of the loan.

406.7(2) *Loan agreement.* A borrower shall enter into a loan agreement with the authority. The borrower will execute and return the loan agreement to the authority within 90 days of the transmittal of the final loan agreement from the authority. Failure to do so may be cause for the board to terminate the award.

406.7(3) *Disbursement of funds.* Borrowers shall submit requests for disbursement of funds in the manner proscribed by the authority.

406.7(4) *Amendment.* Any substantive change to the scope of work for a project or request to renegotiate loan terms shall require an amendment to the loan agreement. The borrower shall request amendments in writing. No substantive amendment shall be valid until approved by the board. The authority may execute nonsubstantive or ministerial changes to the loan agreement without board approval.

406.7(5) *Loan forgiveness.* The board may consider requests for loan forgiveness if the borrower demonstrates forgiveness is necessary to avoid a negative material impact on the project or potential default.

406.7(6) *Closeout.* Upon project completion, the authority will initiate project closeout procedures.

406.7(7) *Recordkeeping and retention.* Borrowers shall retain all financial records, all supporting documents, and all other records pertinent to the loan for five years after the loan agreement is closed or the date the authority issues a written notice of default if the default is not cured.

406.7(8) *Reporting and compliance.* The borrower shall complete all reports required by the loan agreement. The borrower shall submit any information reasonably requested by the authority in sufficient detail to permit the authority to prepare any reports required by the authority, the board, the general assembly or the governor's office. The authority reserves the right to conduct site visits of all awarded projects to ensure the projects were built as proposed and to provide verification of ongoing operation. The authority will monitor all loans to ensure that loan proceeds have been spent as identified in the loan agreement and that all other sources of financing have been committed to the project.

406.7(9) *Default.*

a. At any time during the project or the repayment of the loan, the authority may find that a borrower is in default under the terms of the loan agreement. The authority will take prompt, appropriate, and aggressive debt collection action to recover any funds misspent by borrowers.

b. If the authority determines that a borrower is in default, the authority may seek recovery of the loan plus interest or other penalties, negotiate alternative payment schedules, suspend or discontinue collection efforts, and take other action as the authority deems necessary.

c. The authority shall attempt to collect the amount owed. Any negotiated settlement, write-off, or discontinuance of collection efforts is subject to final review by and approval of the board.

d. If the authority refers a defaulted loan to outside counsel for debt collection, then the terms of the contract between the authority and the outside counsel regarding the scope of counsel's authorization to accept settlements shall apply.

[ARC 0311D, IAB 5/27/26, effective 7/1/26]

These rules are intended to implement Iowa Code sections 15.120 and 476.46A.

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CHAPTER 9
PUBLIC RECORDS AND FAIR INFORMATION PRACTICES

Chapter rescission date pursuant to Iowa Code section 17A.7: 3/26/30

441—9.1(17A,22) Statement of policy, purpose and scope of chapter.

9.1(1) The purpose of this chapter is to facilitate public access to open records. It also seeks to facilitate department determinations with respect to the handling of confidential records and the implementation of the fair information practices Act. The department is committed to the policies set forth in Iowa Code chapter 22; department staff will cooperate with members of the public in implementing the provisions of that chapter.

These rules also implement the federal Health Insurance Portability and Accountability Act (HIPAA) regulations at 45 CFR Parts 160 and 164 as amended to June 25, 2024. These rules set forth the standards the department must meet to protect the privacy of protected health information. The department is a hybrid entity for purposes of HIPAA. The rules on protected health information apply only to those parts of the department that are considered part of the covered entity.

9.1(2) This chapter does not:

- a.* Require the agency to index or retrieve records that contain information about individuals by that person's name or other personal identifier.
- b.* Make available to the general public records that would otherwise not be available under the public records law, Iowa Code chapter 22.
- c.* Govern the maintenance or disclosure of, notification of, or access to records in the possession of the agency that are governed by the rules of another agency.
- d.* Apply to grantees, including local governments or subdivisions thereof, administering state-funded programs.
- e.* Make available records compiled by the agency in reasonable anticipation of court litigation or formal administrative proceedings. The availability of such records to the general public or to any subject individual or party to such litigation or proceedings shall be governed by applicable constitutional principles, statutes, rules of discovery, evidentiary privileges, and applicable rules of the agency.
- f.* Require the agency to create, compare or procure a record solely for the purpose of making it available.

[ARC 8897C, IAB 2/19/25, effective 3/26/25]

441—9.2(17A,22) Definitions. Rescinded ARC 0300D, IAB 5/27/26, effective 7/1/26.

441—9.3(17A,22) Requests for access to records.

9.3(1) *Location of record.* A request for access to a record should be directed to the Records Officer, 321 East 12th Street, Des Moines, Iowa 50319. If a request for access to a record is misdirected, department personnel will promptly forward the request to the department's records officer.

9.3(2) *Office hours.* Open records shall be made available during all customary office hours, which are 8 a.m. to 4:30 p.m. daily, excluding Saturdays, Sundays and legal holidays.

9.3(3) *Request for access.* Requests for access to open records may be made in writing, in person, or by telephone. Requests shall identify the particular records sought by name or description. Mail or telephone requests shall include the name, address, and telephone number of the person requesting the information.

9.3(4) *Response to requests.* Access to an open record will be provided upon request unless the size or nature of the request makes prompt access infeasible. If the size or nature of the request for access to an open record requires time for compliance, the custodian shall comply with the request as soon as feasible. Access to an open record may be delayed for one of the purposes authorized by Iowa Code section 22.8(4) or 22.10(4).

The custodian of a record may deny access to the record by members of the public only on the grounds that such a denial is warranted under Iowa Code sections 22.8(4) and 22.10(4), or that it is a confidential record, or that its disclosure is prohibited by a court order. Access by members of the public to a confidential record is limited by law and, therefore, may generally be provided only in accordance with the provisions of rule 441—9.4(17A,22) and other applicable provisions of law.

9.3(5) *Security of record.* No person may, without permission from the custodian, search or remove any record from department files. Examination and copying of department records shall be supervised by the custodian or a designee of the custodian. Records shall be protected from damage and disorganization.

9.3(6) *Copying.* A reasonable number of copies of an open record may be made in the department office. If photocopy equipment is not available in the department office where an open record is kept, the custodian shall permit its examination in that office and shall arrange to have copies promptly made elsewhere.

9.3(7) *Fees.* The department may charge fees as permitted by Iowa Code chapter 22. The department will publish a fee schedule for open records on its website. The department may charge a fee for the cost of preparing an explanation or summary of health information. The department and the subject requesting the information shall agree to the amount of any fee imposed before the department prepares the explanation or summary.

[ARC 8897C, IAB 2/19/25, effective 3/26/25]

441—9.4(17A,22) Access to confidential records. Under Iowa Code section 22.7 or other applicable provisions of law, the lawful custodian may disclose certain confidential records to one or more members of the public. Other provisions of law authorize or require the custodian to release specified confidential records under certain circumstances or to particular persons. In requesting the custodian to permit the examination and copying of such a confidential record, the following procedures apply and are in addition to those specified for requests for access to records in rule 441—9.3(17A,22).

9.4(1) *Proof of identity.* A person requesting access to a confidential record may be required to provide proof of identity or authority to secure access to the record.

9.4(2) *Requests.* The custodian may require a request to examine and copy a confidential record to be in writing. A person requesting access to such a record may be required to sign a certified statement or affidavit enumerating the specific reasons justifying access to the confidential record and to provide any proof necessary to establish relevant facts.

9.4(3) *Notice to subject of record and opportunity to obtain injunction.* Except as provided in 441—subrule 175.41(2), after the custodian receives a request for access to a confidential record, and before the custodian releases such a record, the custodian may make reasonable efforts to notify promptly any person who is a subject of that record, is identified in that record, and whose address or telephone number is contained in that record. To the extent such a delay is practicable and in the public interest, the custodian may give the subject of such a confidential record to whom notification is transmitted a reasonable opportunity to seek an injunction under Iowa Code section 22.8, and indicate to the subject of the record the specific period of time during which disclosure will be delayed for that purpose.

9.4(4) *Request denied.* When the custodian denies a request for access to a confidential record, the custodian shall promptly notify the requester. If the requester indicates to the custodian that a written notification of the denial is desired, the custodian shall promptly provide such a notification that is signed by the custodian and that includes:

- a. The name and title or position of the custodian responsible for the denial; and
- b. A citation to the provision of law vesting authority in the custodian to deny disclosure of the record and a brief statement of the reasons for the denial to this requester.

9.4(5) *Request granted.* Except as provided in 441—subrule 175.41(2), when the custodian grants a request for access to a confidential record, the custodian shall notify the requester or the

person who is to receive the information and include any limits on the examination and copying of the record.

9.4(6) *Records requiring special procedures.* Special procedures are required for access to:

a. Child abuse information. Access to child abuse information is obtained according to rules 441—175.41(235A) and 441—175.42(235A).

b. Dependent adult abuse information. Access to adult abuse information is governed by rule 441—176.9(235A).

[ARC 8897C, IAB 2/19/25, effective 3/26/25]

441—9.5(17A,22) Requests for treatment of a record as a confidential record and its withholding from examinations. The custodian may treat a record as a confidential record and withhold it from examination only to the extent that the custodian is authorized by Iowa Code section 22.7, another applicable provision of law, or a court order, to refuse to disclose that record to members of the public.

9.5(1) *Persons who may request.* Any person who would be aggrieved or adversely affected by disclosure of a record and who asserts that Iowa Code section 22.7, another applicable provision of law, or a court order, authorizes the custodian to treat the record as a confidential record, may request the custodian to treat that record as a confidential record and to withhold it from public inspection.

9.5(2) *Request.* A request that a record be treated as a confidential record and be withheld from public inspection shall be in writing and shall be filed with the custodian.

a. The request must set forth the legal and factual basis justifying such confidential record treatment for that record, and the name, address, and telephone number of the person authorized to respond to any inquiry or action of the custodian concerning the request.

b. A person requesting treatment of a record as a confidential record may also be required to sign a certified statement or affidavit stating the specific reasons justifying the treatment of that record as a confidential record and to provide any proof necessary to establish relevant facts.

c. Requests to temporarily treat a record as a confidential record shall specify the precise period of time for which that treatment is requested.

d. A person filing such a request shall, if possible, provide a copy of the record in question from which those portions for which such confidential record treatment has been requested have been deleted. If the original record is being submitted to the department by the person requesting confidential treatment at the time the request is filed, the person shall indicate conspicuously on the original record that all or portions of it are confidential.

9.5(3) *Failure to request.* Failure of a person to request confidential record treatment for a record does not preclude the custodian from treating it as a confidential record. However, if a person who has submitted business information to the department does not request that it be withheld from public inspection under Iowa Code section 22.7(3) and 22.7(6), the custodian of records containing that information may proceed as if that person has no objection to its disclosure to members of the public.

9.5(4) *Timing of decision.* A decision by the custodian with respect to the disclosure of a record to members of the public may be made when a request for its treatment as a confidential record that is not available for public inspection is filed, or when the custodian receives a request for access to the record by a member of the public.

9.5(5) *Request granted or deferred.* If a request for such confidential record treatment is granted, or if action on such a request is deferred, a copy of the record from which the matter in question has been deleted and a copy of the decision to grant the request or to defer action upon the request will be made available for public inspection in lieu of the original record. If the custodian subsequently receives a request for access to the original record, the custodian will make reasonable and timely efforts to notify any person who has filed a request for its treatment as a confidential record that is not available for public inspection of the pendency of that subsequent request.

9.5(6) *Request denied and opportunity to seek injunction.* If a request that a record be treated as a confidential record and be withheld from public inspection is denied, the custodian shall notify the requester in writing of that determination and the reasons therefor. On application by the requester,

the custodian may engage in a good faith, reasonable delay in allowing examination of the record so that the requester may seek injunctive relief under the provisions of Iowa Code section 22.8, or other applicable provision of law. However, such a record shall not be withheld from public inspection for any period of time if the custodian determines that the requester had no reasonable grounds to justify the treatment of that record as a confidential record. The custodian shall notify requester in writing of the time period allowed to seek injunctive relief or the reasons for the determination that no reasonable grounds exist to justify the treatment of that record as a confidential record. The custodian may extend the period of good faith, reasonable delay in allowing examination of the record so that the requester may seek injunctive relief only if no request for examination of that record has been received, or if a court directs the custodian to treat it as a confidential record, or to the extent permitted by another applicable provision of law, or with the consent of the person requesting access.

9.5(7) *Requesting privacy protection for protected health information.*

a. Requesting restrictions on protected health information use or disclosure. The department will follow the requirements of 45 CFR §164.522 as amended to March 26, 2013, in responding to these requests.

b. Requesting the receipt of communications of protected health information by alternative means or at alternative locations. The department will follow the requirements of 45 CFR §164.522 as amended to March 26, 2013, in responding to these requests. For Medicaid and hawki, the subject is required to clearly indicate the reason for requesting the confidential communication. Facilities shall not require the subject to explain the basis for the request as a condition of providing confidential communications.

[ARC 8897C, IAB 2/19/25, effective 3/26/25]

441—9.6(17A,22) Procedure by which additions, dissents, or objections may be entered into certain records.

9.6(1) *All programs.* Except as otherwise provided by law, a subject may file a request with the custodian to review, and to have a written statement of additions, dissents, or objections entered into, a record containing personally identifiable information pertaining to that subject. However, the subject is not authorized to alter the original copy of the record or to expand the official record of any department proceeding.

a. The subject shall send the request to review such a record or the written statement of additions, dissents, or objections to the department.

b. The request to review such a record or the written statement of additions, dissents, or objections must be dated and signed by the subject and shall include the current address and telephone number of the subject or the subject's representative.

9.6(2) *Additional procedures for protected health information.* The department will follow the protected health information right to amend standards as outlined in 45 CFR §164.526 as amended to March 26, 2013. The subject shall provide a reason to support the requested amendment.

[ARC 8897C, IAB 2/19/25, effective 3/26/25]

441—9.7(17A,22,228) Consent to disclosure by the subject of a confidential record. To the extent permitted by any applicable provision of law, the subject of a confidential record may have a copy of the portion of that record concerning the subject disclosed to a third party. A request for such a disclosure must be in writing and must identify the particular record or records to be disclosed, the particular person or class of persons to whom the record may be disclosed, and the time period during which the record may be disclosed. The subject of the record and, where applicable, the person to whom the record is to be disclosed may be required to provide proof of identity. Appearance of counsel before the department on behalf of a person who is the subject of a confidential record is deemed to constitute consent for the department to disclose records about that person to the person's attorney. An attorney requesting access to a confidential record may be required to provide proof of identity or authority to secure access to the record. No confidential information about clients of the department shall be released without the client's consent, except as otherwise provided by law.

Release of confidential information includes granting access to or allowing the copying of a record, providing information either in writing or orally, or acknowledging information to be true or false.

9.7(1) Release forms.

a. Releases allowing the department to provide confidential information, including protected health information. Subjects should complete an authorization for release on a form that meets the requirements of applicable law.

b. Releases allowing the department to provide protected health information under HIPAA. The department shall not require a subject to sign a HIPAA authorization form as a condition of treatment, payment, enrollment in a health plan, or eligibility for benefits. The department as a health care provider may require a subject to sign a HIPAA authorization form for the use or disclosure of protected health information for research, as a condition of the subject's receiving research-related treatment. A subject may revoke a HIPAA authorization at any time, provided that the revocation is in writing using a form that meets the requirements of applicable law, except to the extent that the department has taken action in reliance thereon.

c. Releases allowing the department to obtain confidential information from a third party. The department is required to obtain confidential information from third parties. The department may make these requests unless prohibited by applicable law or when the client has authorized the release on one of the following forms:

- (1) Authorization for Release of Information.
- (2) Household Member Questionnaire.
- (3) Bank or Credit Union Information.
- (4) Addendum for Application and Review Forms for Release of Information.
- (5) Request for School Verification.
- (6) Employer's Statement of Earnings.
- (7) Verification of Educational Financial Aid.
- (8) Financial Institution Verification.
- (9) Authorization to Obtain or Release Health Care Information.

d. Releases for photographs and recordings. The department may seek permission to use photographs in department publications on a form that meets the requirements of applicable law. The department will obtain authorization from the subject or person responsible (such as a guardian, custodian, or personal representative) for the subject before taking photographs or making any type of recording for any purpose other than those specifically allowed by law or for internal use within an institution.

9.7(2) Exceptions to use of release forms.

a. Public official. A letter from the subject to a public official that seeks the official's intervention on behalf of the subject in a matter that involves the department shall be treated as an authorization to release information upon receipt of appropriate authorization from the subject to do so. The department shall release only the minimum amount of information necessary about the subject to the official to resolve the matter. If the information includes protected health information, the department may only provide the protected health information if, in the exercise of professional judgment, the department determines that disclosure is in the best interest of the subject. When the department determines that disclosure is in the subject's best interest, the department may disclose only the protected health information that is directly relevant to the public official's intervention with the matter involving the department.

b. Medical emergency. Department staff may authorize release of confidential information to medical personnel in a medical emergency if the subject is unable to give or withhold consent. As soon as possible after the release of information, the subject shall be advised of the release.

c. Abuse information. Consent to release information is not required to gather information for investigations of child abuse or dependent adult abuse.

9.7(3) Opportunity for subject to agree or object for protected health information under HIPAA. This subrule describes when the department may use or disclose protected health information, without

a written authorization, to persons involved in the subject's care and for notification purposes. However, the department shall give the subject an opportunity to agree or object unless this requirement is waived as specified in paragraph 9.7(3) "e."

a. Involvement in the subject's care. The department may, in accordance with paragraphs 9.7(3) "c," "e," and "f," disclose protected health information that is directly relevant either to a subject's care or to payment related to the subject's care, provided payment is relevant to the person's involvement in the subject's care. The person involved must be:

- (1) A family member;
- (2) Another relative;
- (3) A close personal friend of the subject; or
- (4) Any other person identified by the subject.

b. Notification purposes. The department may use or disclose protected health information to notify, or assist in notifying, identifying or locating a family member, a personal representative of the subject, or another person responsible for the care of the subject of the subject's location, general condition or death. For disaster relief purposes, the use or disclosure shall be in accordance with paragraph 9.7(3) "f."

c. Uses and disclosures with the subject present. If the subject is present for, or available before, a use or disclosure permitted by this subrule and has the capacity to make health care decisions, the department may use or disclose the protected health information if the department:

- (1) Obtains the subject's agreement;
- (2) Provides the subject with the opportunity to object to the disclosure, and the subject does not express an objection; or
- (3) Reasonably infers from the circumstances, based on the exercise of professional judgment, that the subject does not object to the disclosure.

d. Informing the subject. The department may orally inform the subject of and obtain the subject's oral agreement or objection to a use or disclosure permitted by this subrule.

e. Limited uses and disclosures when the subject is not present. When the subject is not present, or the opportunity to agree or object to the use or disclosure cannot practicably be provided because of the subject's incapacity or an emergency circumstance, the department may, in the exercise of professional judgment, determine that disclosure is in the best interest of the subject.

(1) When the department determines that disclosure is in the subject's best interest, the department may disclose only the protected health information that is directly relevant to the person's involvement with the subject's health care.

(2) The department may use professional judgment and its experience with common practice to make reasonable inferences of the subject's best interest in allowing a person to act on behalf of the subject to pick up filled prescriptions, medical supplies, X-rays, or other similar forms of protected health information.

f. For disaster relief purposes. The department may use protected health information or disclose protected health information to a public or private organization authorized by law or by its charter to assist in disaster relief efforts for the purpose of coordinating with these organizations the uses or disclosures permitted by paragraph 9.7(3) "b." The requirements in paragraphs 9.7(3) "c" and "d" apply to these uses and disclosures to the extent that the department, in the exercise of professional judgment, determines that the requirements do not interfere with the ability to respond to the emergency circumstances.

[ARC 8897C, IAB 2/19/25, effective 3/26/25]

441—9.8(17A,22) Notice to suppliers of information. When the department requests a person to supply information about that person, the department shall notify the person of how the information will be used, which entities outside the department might routinely be provided this information, which parts of the requested information are required and which are optional, and the consequences of a failure to provide the information requested. This notice may be given in these rules, on the

written form used to collect the information, on a separate fact sheet or letter, in brochures, in formal agreements, in contracts, in handbooks, in manuals, verbally, or by other appropriate means. The notice shall generally be given at the first contact with the department and need not be repeated. Where appropriate, the notice may be given to a person's legal or personal representative. Notice may be withheld in an emergency or where it would compromise the purpose of a department investigation. [ARC 8897C, IAB 2/19/25, effective 3/26/25]

441—9.9(17A,22) Release to subject. The department will follow the access of individuals to protected health information standards as outlined in 45 CFR §164.524 as amended to February 6, 2014. If the department does not maintain the protected health information that is the topic of the subject's request for access, and the department knows where the requested information is maintained, the department shall inform the subject where to direct the request for access.

[ARC 8897C, IAB 2/19/25, effective 3/26/25]

441—9.10(17A,22) Use and disclosure without consent of the subject. Open records are routinely disclosed without the consent of the subject. To the extent allowed by law, the department may also use and disclose confidential information without the consent of the subject or the subject's representative.

9.10(1) Routine use. To the extent allowed by law, the following are considered routine uses of all department records:

a. Disclosure to employees and agents of the department as needed for the performance of their duties.

b. Transfers of information within the department, to other state or federal agencies, agents of tribes and tribal public health authorities, or to local units of government as necessary to administer the program for which the information is collected or as necessary to administer a program within the other entity.

c. To a recipient who has provided the department with advance written assurance that the record will be used solely to create a statistical report. The department shall not release confidential data or information pursuant to this chapter unless the department and the recipient have executed an agreement that includes the conditions under which the confidential data or information may be used and a restriction on the further disclosure of the data or information.

9.10(2) Audits and health oversight activities.

a. Audits. Information concerning program expenditures and client eligibility is released to staff of the state executive and legislative branches who are responsible for ensuring that public funds have been managed correctly. Information is also released to auditors from federal agencies when those agencies provide program funds.

b. Health oversight activities. The department will follow the uses and disclosures standards for health oversight activities as outlined in 45 CFR §164.512 as amended to June 25, 2024.

9.10(3) Program review. Information concerning client eligibility and benefits is released to state or federal officials responsible for determining whether the department is operating a program lawfully. These officials include the ombudsman office under Iowa Code section 2C.9, the auditor of state under Iowa Code section 11.2, the Office of Inspector General in the federal Department of Health and Human Services, and the Centers for Medicare and Medicaid Services.

9.10(4) Contracts and agreements with agencies and persons.

a. The department may enter into contracts or agreements with public or private agencies to carry out the department's official duties or as necessary to administer a program within the other agency. Information necessary to carry out these duties may be shared with these agencies. The department may disclose protected health information to a business associate and may allow a business associate to create or receive protected health information on its behalf if the department obtains satisfactory assurance that the business associate will appropriately safeguard the information.

b. The department may enter into agreements to share information with agencies administering federal or federally assisted programs which provide assistance or services directly to persons on the

basis of need. Only information collected in the family investment program, the child care assistance program, the food assistance program, the refugee resettlement program, or the child support recovery program may be shared under these agreements.

c. To meet federal income and eligibility verification requirements, the department has entered into agreements with the department of workforce development, the United States Internal Revenue Service, and the United States Social Security Administration. The department obtains information regarding persons whose income or resources are considered in determining eligibility and the amount of benefits for the family investment program, refugee cash assistance, child care assistance, food assistance, Medicaid, state supplementary assistance and foster care. Identifying information regarding clients of these programs is released to these agencies. The information received may be used for eligibility and benefit determinations.

d. To meet federal requirements under the Immigration Reform and Control Act of 1986 (IRCA) relating to the Systematic Alien Verification for Entitlements (SAVE) program, the department has entered into an agreement with the Bureau of Citizenship and Immigration Service (BCIS). Under the agreement, the department exchanges information necessary to verify alien status for the purpose of determining eligibility and the amount of benefits for the family investment program, refugee cash assistance, food assistance, Medicaid, state supplementary assistance and foster care assistance. Identifying information regarding these subjects is released to the BCIS. The information received may be used for eligibility and benefit determinations.

e. The department has entered into an agreement with the department of workforce development to provide services to family investment program clients participating in the PROMISE JOBS program as described at 441—Chapter 93. Information necessary to carry out these duties shall be shared with the department of workforce development, as well as with its subcontractors.

f. The department has entered into an agreement with the department of education, vocational rehabilitation, disability determination services, to assist with Medicaid disability determinations.

g. The department has entered into an agreement with the department of education to share information that assists both schools and department clients in carrying out the annual verification process required by the United States Department of Agriculture, Food and Nutrition Service. That federal agency requires the department of education and local schools to verify eligibility of a percentage of the households approved for free-meal benefits under the school lunch program. When a department office receives a written request from the local school, the department office responds in writing with the current family investment program and food assistance program status of each recipient of free meals listed in the request. Other client-specific information is made available only with written authorization from the client.

9.10(5) Release for judicial and administrative proceedings. Information is released to the court as required in Iowa Code sections 125.80, 125.84, 125.86, 229.8, 229.10, 229.13, 229.14, 229.15, 229.22, 232.48, 232.49, 232.52, 232.71B, 232.81, 232.97, 232.98, 232.102, 232.111, 232.117 and 235B.3.

a. The department may disclose protected health information in the course of any judicial or administrative proceeding in response to an order of a court or administrative tribunal, provided that the department discloses only the protected health information expressly authorized by the order and the court makes the order knowing that the information is confidential.

b. When a court subpoenas information that the department is prohibited from releasing, the department shall advise the court of the statutory and regulatory provisions against disclosure of the information and shall disclose the information only on order of the court.

9.10(6) Fraud. Information concerning suspected fraud or misrepresentation to obtain department services or assistance is disclosed to DIAL and to law enforcement authorities.

9.10(7) Service referrals. Information concerning clients may be shared with purchase of service providers under contract to the department.

a. Information concerning the client's circumstances and need for service is shared with prospective providers to obtain placement for the client. If the client is not accepted for service, all written information released to the provider shall be returned to the department.

b. When the information needed by the provider is mental health information or substance abuse information, the subject's specific consent is required.

9.10(8) *Medicaid billing.* Only the following information shall be released to bona fide providers of medical services in the event that the provider is unable to obtain it from the subject and is unable to complete the Medicaid claim form without it:

- a.* Patient identification number.
- b.* Health coverage code as reflected on the subject's medical card.
- c.* The subject's date of birth.
- d.* The subject's eligibility status for the month that the service was provided.
- e.* The amount of spenddown.
- f.* The bills used to meet spenddown.

9.10(9) Reserved.

9.10(10) *Child support recovery.* The child support recovery unit has access to information from most department records for the purpose of establishing and enforcing support obligations. Information about absent parents and recipients of child support services is released according to the provisions of Iowa Code chapters 234, 252A, 252B, 252C, 252D, 252E, 252F, 252G, 252H, 252I, 252J, 252K, 598, and 600B and any other support chapter. Information is also released to consumer reporting agencies as specified in rule 441—98.116(252B).

9.10(11) *Refugee resettlement program.* Contacts with both sponsor and resettlement agencies are made as a part of the verification process to determine eligibility or the amount of assistance. When a refugee applies for cash or Medicaid, the refugee's name, address, and telephone number are given to the refugee's local resettlement agency.

9.10(12) *Abuse investigation.* The central abuse registry disseminates child abuse information and dependent adult abuse information as provided in Iowa Code sections 235A.15 and 235B.7, respectively. Reports of child abuse and dependent adult abuse investigations are submitted to the county attorney as required in Iowa Code sections 232.71B and 235B.3. Results of the investigation of a report by a mandatory reporter are communicated to the reporter as required in Iowa Code sections 235A.17(2) and 235A.15(2) "b"(5).

9.10(13) *Foster care.* Information concerning a child's need for foster care is shared with foster care review committees or foster care review boards and persons named in the case permanency plan.

9.10(14) *Adoption.* Adoptive home studies completed on families who wish to adopt a child are released to licensed child-placing agencies, to the United States Immigration and Naturalization Service, and to adoption exchanges. Information is released from adoption records as provided in Iowa Code sections 600.16 and 600.24.

9.10(15) *Disclosures to law enforcement.*

a. Disclosures by workforce members who are crime victims. The department is not considered to have violated the requirements of this chapter if a member of its workforce who is the victim of a criminal act discloses confidential information to a law enforcement official, provided that:

(1) The confidential information disclosed is about the suspected perpetrator of the criminal act and intended for identification and location purposes; and

(2) The confidential information disclosed is limited to the following information:

- 1. Name and address.
- 2. Date and place of birth.
- 3. Social security number.
- 4. ABO blood type and Rh factor.
- 5. Type of injury.
- 6. Date and time of treatment.
- 7. Date and time of death, if applicable.

8. A description of distinguishing physical characteristics, including height, weight, gender, race, hair and eye color, presence or absence of facial hair (beard or moustache), scars, and tattoos.

b. Crime on premises. The department may disclose to a law enforcement official protected health information that the department believes in good faith constitutes evidence of criminal conduct that occurred on the premises of the department.

c. Decedents. The department may disclose protected health information to a law enforcement official about a subject who has died when the death resulted from child abuse or neglect or the death occurred in a department facility.

d. Other. The department may disclose confidential information to a law enforcement official when otherwise required or allowed by this chapter, such as disclosures about victims of child abuse or neglect; disclosures to avert a threat to health or safety, or to report suspected fraud; disclosures required by due process of law, such as disclosures for judicial and administrative proceedings; or other disclosures required by law.

9.10(16) Response to law enforcement. The address of a current recipient of family investment program benefits may be released upon request to a federal, state or local law enforcement officer if the officer provides the name of the recipient, and the officer demonstrates that:

a. The recipient is a fugitive felon who is fleeing prosecution, custody or confinement after conviction under state or federal law, or who is a probation or parole violator under state or federal law, or

b. The recipient has information that is necessary for the officer to conduct the officer's official duties, and

c. The location or apprehension of the recipient is within the officer's official duties.

9.10(17) Research and evaluation. Disclosure is made to employees of federal, state and local agencies and other investigators for purposes of bona fide research or evaluation. The department shall not release data or information pursuant to this paragraph unless the department and the researcher have executed an agreement that includes the conditions under which the confidential data or information may be used and restrictions on further disclosure of the data or information.

a. Mental health information may be disclosed for purposes of scientific research as provided in Iowa Code sections 228.5 and 229.25. Requests to do research involving records of a department facility shall be approved by the designated authority.

b. Abuse registry information may be disclosed for research purposes as provided in rules 441—175.42(235A) and 441—176.12(235B) and authorized by Iowa Code sections 235A.15(2) "e" (1) and 235B.6(2) "e" (1).

c. For research relating to protected health information, the researcher shall provide the department with information about the nature of the research, the protocol, the type of information being requested, and any other relevant information that is available concerning the request. If the researcher feels that contact with the subject is needed, the researcher shall demonstrate to the department that the research cannot be conducted without contact with the subject. The researcher shall pay for the costs of obtaining authorizations needed to contact the subjects and for the cost of files and preparation needed for the research.

9.10(18) Threat to health or safety.

a. All programs. A client's name, identification, location, and details of a client's threatened or actual harm to department staff or property may be reported to law enforcement officials. Other information regarding the client's relationship to the department shall not be released. When a department staff person believes a client intends to harm someone, the staff person may warn the intended victim or police or both. Only the name, identification, and location of the client and the details of the client's plan of harm shall be disclosed.

b. Protected health information. The department will follow the disclosure standards in 45 CFR §164.512 as amended to June 25, 2024.

9.10(19) Required by law.

a. Information is shared with other agencies without a contract or written agreement when federal law or regulations require it.

b. The department may use or disclose protected health information to the extent that use or disclosure is required by law and the use or disclosure complies with and is limited to the relevant requirements of the law.

c. State law shall preempt rules in this chapter about protected health information when any one of the following conditions exists:

(1) Exception granted by Secretary of Health and Human Services under 45 CFR §160.204 as amended to March 26, 2013.

(2) State law more stringent. The provision of state law relates to the privacy of protected health information and is more stringent than a requirement of this chapter, within the meaning of “more stringent” found at 45 CFR §160.202 as amended to March 26, 2013.

(3) Reporting requirements. The provision of state law, including state procedures established under the law, as applicable, provides for the reporting of disease or injury, child abuse, birth, or death, or for the conduct of public health surveillance, investigation, or intervention.

(4) Requirements related to audits, monitoring, evaluation, licensing, and certification. The provision of state law requires a health plan to report, or to provide access to, information for the purpose of management audits, financial audits, program monitoring and evaluation, or the licensure or certification of facilities and persons.

9.10(20) *Treatment, payment, or health care operations.*

a. The department may use or disclose protected health information for treatment, payment, or health care operations, as permitted by 45 CFR §164.506 as amended to March 26, 2013, except for psychotherapy notes, which are subject to the limits described in paragraph 9.10(21)“*b.*” The use or disclosure shall be consistent with other applicable requirements of this chapter.

b. The department may use or disclose psychotherapy notes without an authorization for any one of the following reasons:

(1) To carry out the following treatment, payment, or health care operations:

1. Use by the originator of the psychotherapy notes for treatment.

2. Use or disclosure by the department for its own training programs in which students, trainees, or practitioners in mental health learn under supervision to practice or improve their skills in group, joint, family, or individual counseling.

3. Use or disclosure by the department to defend itself in a legal action or other proceeding brought by the subject.

(2) When required by the Secretary of Health and Human Services to investigate or determine the department’s compliance with federal HIPAA regulations.

(3) For health oversight activities with respect to the oversight of the originator of the psychotherapy notes.

(4) When necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public as described in this chapter.

(5) When required by law as described in this chapter.

(6) To disclose protected health information in the designated record set to a coroner or medical examiner as described in this chapter.

9.10(21) *Other uses and disclosures for which an authorization or opportunity to agree or object is not required.* The department may use or disclose protected health information for which an authorization or opportunity to agree or object is not required as permitted by 45 CFR §164.512 as amended to June 25, 2024.

9.10(22) *Victims of domestic violence.* The department shall disclose confidential information about an individual whom the department reasonably believes to be a victim of domestic violence when required by state law.

9.10(23) *Whistle blowers.* The department is not considered to have violated the requirements of this chapter when a member of its workforce or a business associate discloses protected health information, provided that:

a. The workforce member or business associate has a good-faith belief that the department or a business associate has engaged in conduct that is unlawful or otherwise violates professional or clinical standards, or has provided care, services, or conditions that potentially endanger one or more patients, workers, or the public; and

b. The disclosure is made to one of the following:

(1) A health oversight agency or public health authority authorized by law to investigate or oversee conduct or conditions for the purpose of reporting the allegation of failure to meet professional standards or misconduct.

(2) An appropriate health care accreditation organization.

(3) An attorney retained by or on behalf of the workforce member or business associate for the purpose of determining the legal options of the workforce member or business associate.

9.10(24) *Secondary to a use or disclosure of protected health information.* The department may use or disclose protected health information that is secondary to a use or disclosure otherwise permitted or required by these rules, such as when a visitor in a facility overhears a doctor speaking to a subject about the subject's health.

9.10(25) *De-identified data or a limited data set.* The department may use or disclose protected health information to create information that is de-identified or a limited data set under the conditions specified in 45 CFR §164.514 as amended to June 7, 2013.

[ARC 8897C, IAB 2/19/25, effective 3/26/25]

441—9.11(22) Availability of records.

9.11(1) *Open records.* Department records are open for public inspection and copying unless otherwise provided by rule or law.

9.11(2) *Confidential records.* Iowa Code chapters governing the operations of the department establish the confidential nature of many department records. The department also administers several federally funded programs and is authorized by Iowa Code section 22.9 to enforce confidentiality standards from federal law and regulation as required for receipt of the funds where the department has determined that the right to examine and copy public records under Iowa Code section 22.2 would cause the denial of funds, services, or essential information from the United States government that would otherwise be available to the department.

9.11(3) *Authority to release confidential records.* The department may have discretion to disclose some confidential records that are exempt from disclosure under Iowa Code section 22.7 or other provision of law.

[ARC 8897C, IAB 2/19/25, effective 3/26/25]

441—9.12(22,252G) Personally identifiable information. Rescinded ARC 0300D, IAB 5/27/26, effective 7/1/26.

441—9.13(17A,22) Special policies and procedures for protected health information. The department will follow all special policies and procedures for using and disclosing protected health information as outlined in 45 CFR Part 164 as amended through December 31, 2023, including the minimum necessary standard, uses and disclosures for premium rating and related purposes, verification and documentation requirements, notice of privacy practices, the right to receive an accounting of disclosures, complaint procedures, appeal rights and record retention.

[ARC 8897C, IAB 2/19/25, effective 3/26/25]

441—9.14(17A,22) Person who may exercise rights of the subject.

9.14(1) Adults. When the subject is an adult, including an emancipated minor, the subject's rights under this rule may also be exercised by the subject's legal or personal representative, except as provided in subrule 9.14(3).

9.14(2) Minors. Within the limits of subrule 9.14(3), when the subject is an unemancipated minor, the subject's rights under this rule shall be exercised only by the subject's legal representative, except as follows:

a. When the department otherwise deals with the minor as an adult, as in the case of minor parents under the family investment program.

b. When otherwise specifically provided by law. However, minor subjects shall be granted access to their own records upon request, subject to the limits in rule 441—9.9(17A,22).

9.14(3) Exceptions.

a. Scope of authority. Legal and personal representatives may act only within the scope of their authority. For protected health information, the designation must reflect the subject's ability to make health care decisions and receive protected health information. For example, court-appointed conservators shall have access to and authority to release only the following information:

- (1) Name and address of subject.
- (2) Amounts of assistance or type of services received.
- (3) Information about the economic circumstances of the subject.

b. Mental health information. Only an adult subject or a subject's legal representative may consent to the disclosure of mental health information. Records of involuntary hospitalization shall be released only as provided in Iowa Code section 229.24. Medical records of persons hospitalized under Iowa Code chapter 229 shall be released only as provided in Iowa Code section 229.25.

c. Substance abuse information. Only the subject may consent to the disclosure of substance abuse information, regardless of the subject's age or condition.

d. Failure to act in good faith. If the department has reason to believe that the legal or personal representative is not acting in good faith in the best interests of the subject, the department may refuse to release information on the authorization of the legal or personal representative.

e. Abuse, neglect, and endangerment situations. Notwithstanding a state law or any other requirement of this chapter, the department, in the exercise of professional judgment, may elect not to treat a person as a subject's personal representative if:

- (1) The department has reason to believe that the subject has been or may be subjected to domestic violence, abuse, or neglect by the person; or
- (2) The department has reason to believe that treating the person as a personal representative could endanger the subject.

f. Protected health information. A parent, guardian, or other person acting in place of a parent who does not represent the minor for protected health information may still access protected health information about the minor if required by law.

g. Deceased subjects. If, under applicable law, an executor, administrator, or other person has authority to act on behalf of a deceased subject or of the subject's estate, the department shall treat that person as a personal representative.

h. Other. If, under applicable law, the subject of a confidential record is precluded from having a copy of a record concerning the subject disclosed to a third party, the department shall not treat the third party as a personal representative.

[ARC 8897C, IAB 2/19/25, effective 3/26/25]

These rules are intended to implement Iowa Code chapters 17A, 22, 135, 217, 228, and 252G and the Health Insurance Portability and Accountability Act of 1996.

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¹ The effective date of **ARC 7711C** was corrected to July 1, 2024, in the April 3, 2024, Iowa Administrative Bulletin.

TITLE VIII
MEDICAL ASSISTANCECHAPTER 73
MANAGED CARE

Chapter rescission date pursuant to Iowa Code section 17A.7: 7/1/31

441—73.1(249A) Definitions.

“Appeal” means a review by an MCO or PAHP of an adverse benefit determination as specified in 42 CFR 438.400(b).

“Capitation payment” means a monthly payment to the MCP on behalf of each enrollee for the provision of health or dental services under the contract. Payment is made regardless of whether the enrollee receives services during the month.

“Choice counseling” means the provision of unbiased information on MCPs or provider options and answers to related questions and access to personalized assistance to help members understand the materials provided by the MCPs or the state, to answer questions about each of the options available, and to facilitate enrollment with an MCP.

“Claim” means a formal request for payment for benefits received or services rendered.

“Clean claim” means a claim that has no defect or impropriety (including any lack of required substantiating documentation) or particular circumstance requiring special treatment that prevents timely payment of the claim. “Clean claim” does not include a claim from a provider that is under investigation for fraud or abuse or a claim under review for medical necessity.

“CMS” means the Centers for Medicare and Medicaid Services, a division of the U.S. Department of Health and Human Services.

“Code of Federal Regulations” or *“CFR”* means the codification of the general and permanent rules published in the Federal Register by the executive departments and agencies of the federal government, and all references herein are as amended to July 1, 2026.

“Community-based case management” means a collaborative process of planning, facilitation, and advocacy for options and services to meet an enrollee’s needs through communication and available resources to promote high-quality, cost-effective outcomes.

“Contract” means a contract between the department and an MCP. These contracts shall meet all applicable requirements of state and federal law, including the requirements of 42 CFR 434.

“Covered services” means physical health, behavioral health, dental, and long-term care services set forth in rule 441—73.5(249A).

“Discharge planning” means the process, which begins at admission, of determining a continued need for treatment services and of developing a plan to address ongoing needs.

“Electronic visit verification system” or *“EVV system”* means an electronic system that providers can check into at the beginning of and check out of at the end of each period of service delivery to monitor enrollees’ receipt of care.

“Emergency medical condition” means the same as defined in 42 CFR 438.114(a).

“Emergency services” means the same as defined in 42 CFR 438.114(a).

“Enrollee” means a hawki, IHAWP, dental wellness plan or Medicaid member who is eligible for MCP enrollment and has been enrolled with an MCP as described in subrule 73.3(2).

“Enrollment broker” means the entity the department uses to enroll persons in an MCP. The enrollment broker must be conflict-free and meet all applicable requirements of state and federal law, including 42 CFR 438.10.

“Hawki program” means the healthy and well kids in Iowa program as set forth in 441—Chapter 86, the Iowa program to provide health care coverage for uninsured children of eligible families as authorized by Title XXI of the federal Social Security Act as amended to July 1, 2026.

“HIPPI” means the health insurance premium payment program.

“Home- and community-based services” or *“HCBS”* means services that are provided as an alternative to long-term care institutional services in a nursing facility or an intermediate care facility for persons with an intellectual disability (ICF/ID) or to delay or prevent placement in a nursing facility or ICF/ID.

“Incident reporting” means the reporting of critical events or incidents deemed sufficiently serious to warrant near-term review and follow-up by an appropriate authority. Such incidents may include but are not limited to:

1. Abuse and neglect;
2. The unauthorized use of restraint, seclusion or restrictive interventions;
3. Serious injuries that require medical intervention or result in hospitalization, or both;
4. Criminal victimization;
5. Death;
6. Financial exploitation;
7. Medication errors; and
8. Other incidents or events that involve harm or risk of harm to a participant.

“Iowa health and wellness plan” or *“IHAWP”* means the medical assistance program set forth in 441—Chapter 74.

“Level of care” refers to the amount, type, and intensity of medical care services required to meet an individual’s health and safety needs.

“Long-term care” or *“LTC”* means the services of a nursing facility (NF); an ICF/ID; the Woodward state resource center; or services funded through Section 1915(c) HCBS waivers, the Section 1915(i) habilitation program, and the PACE program outlined in 441—Chapter 88.

“Managed care organization” or *“MCO”* means an entity that (1) is under contract with the department to provide services to Medicaid recipients and (2) meets the definition of “health maintenance organization” in Iowa Code section 514B.1.

“Managed care plan” or *“MCP”* refers to MCOs and PAHPs. The benefits provided through managed care will be paid for by the MCP participating in the programs pursuant to this chapter, subject to the conditions, procedures, and payment rates or methodologies established by the MCP, consistent with this chapter and with the contract between the department and the MCP.

“Mandatory enrollment” means mandatory participation in a managed care plan as specified in subrule 73.3(2).

“Medical loss ratio” means the percentage of capitation payments that is used to pay medical or dental expenses.

“Medically necessary services” means those covered services that are under the terms and conditions of the contract and 42 CFR 438.54(b)(2).

“Member” means any person determined by the department to be eligible for the Medicaid program, hawki program, IHAWP, or dental wellness plan.

“Money Follows the Person (MFP) Rebalancing Demonstration Grant” means a federal grant that will assist Iowa in transitioning individuals from an NF or ICF/ID into the community and in rebalancing long-term care expenditures.

“Needs-based eligibility” means an evaluation to determine and establish an individual’s need for habilitation services.

“Network” or *“provider network”* means a group of participating health or dental care providers (both individual and group practitioners) linked through contractual arrangements to the MCP to supply a range of health or dental care services.

“Out-of-network provider” means any provider that is not directly or indirectly employed by or does not have a provider agreement with the MCP or any of its subcontractors pursuant to the contract between the department and the MCP.

“Participating providers” means the providers of covered physical health, behavioral health, dental, and long-term care services that have contracted with a managed care plan.

“Passive enrollment process” means the process by which the department assigns a member to a managed care plan and that, in accordance with 42 CFR 438.54, seeks to preserve existing provider-member relationships and relationships with providers that have traditionally served Medicaid members, if possible. In the absence of existing relationships, the process ensures that members are equally distributed among all available managed care plans.

“Prepaid ambulatory health plan” or *“PAHP”* has the meaning set forth in 42 CFR 438.2.

“Prior authorization” means the process of obtaining prior approval as to the appropriateness of a service or medication. Prior authorization does not guarantee coverage.

[ARC 0312D, IAB 5/27/26, effective 7/1/26]

441—73.2(249A) Contracts with a managed care plan (MCP).

73.2(1) The department may enter into a contract with an MCP licensed under the provisions of insurance division rules set forth in 191—Chapter 40 for the scope of services as described in rule 441—73.6(249A).

73.2(2) The department will determine that the MCP meets the following requirements:

a. The MCP shall make available services to enrollees as established in the contract.

b. The MCP shall provide satisfaction to the department against the risk of insolvency and ensure that neither Medicaid members nor the state shall be responsible for the MCP’s debts if the MCP becomes insolvent. The MCP shall comply with the insurance division of the Iowa department of insurance and financial services provisions set forth in rule 191—40.12(514B) regarding net worth and rule 191—40.14(514B) containing reporting requirements.

c. The MCP shall attain and maintain accreditation by the National Committee for Quality Assurance (NCQA) or URAC.

73.2(3) If not already accredited, the MCP must demonstrate it has initiated the accreditation process as of the contract effective date and must achieve accreditation at the earliest date allowed by NCQA or URAC. Prior to the contract effective date, the MCP must be licensed and in good standing in the state of Iowa as a health maintenance organization in accordance with 191—Chapter 40.

[ARC 0312D, IAB 5/27/26, effective 7/1/26]

441—73.3(249A) Enrollment.

73.3(1) *Enrollment area.* The coverage area for enrollment shall be statewide.

73.3(2) *Members subject to enrollment.* All hawki program, IHAWP, and dental wellness plan members shall be subject to mandatory enrollment in an MCP. All Medicaid members, with the exception of the following, shall be subject to mandatory enrollment in an MCP:

- a. Members who are medically needy as described in rule 441—75.8(249A).
- b. Individuals eligible only for emergency medical services because the individuals do not meet citizenship or alienage requirements pursuant to 441—Chapter 75.
- c. Persons who are currently presumptively eligible as defined in 441—Chapter 75.
- d. Persons eligible for PACE who voluntarily elect PACE coverage as described in 441—Chapter 88.
- e. Persons enrolled in HIPP pursuant to 441—Chapter 75.
- f. Persons eligible only for the Medicare savings program as described in 441—Chapters 75 and 76.
- g. American Indian and Alaska Native populations who are exempt from mandatory enrollment pursuant to 42 CFR 438.50(d)(2) but who may enroll voluntarily.
- h. Persons who have a Medicaid eligibility period that is retroactive as described in 441—Chapter 76.
- i. Persons who are inmates of a public institution and ineligible for Medicaid benefits as described in 441—Chapter 75.
- j. Persons residing in the Iowa veterans home as described in 801—Chapter 10.

73.3(3) Enrollment process. The department will notify members who must be enrolled in an MCP of enrollment and the effective date of enrollment. The department will implement an enrollment process in accordance with federal funding requirements, including 42 CFR 438.54.

a. General. Members may receive MCP choice counseling from the enrollment broker. The enrollment broker will provide information about individual MCP benefit structures, services and network providers, as well as information about other Medicaid programs as requested by the Medicaid member to assist the member in making an informed selection.

b. Auto-assignment. Effective no earlier than the first day of the month of the member's application to Medicaid, the member will be assigned to an MCP using the department's auto-enrollment process and offered the opportunity to choose from the available MCPs within a time frame specified in the auto-assignment letter.

c. Request to change enrollment. An enrollee may, within 90 days of initial enrollment, request to change enrollment from one MCP and enroll in another MCP. The request may be made on a form designated by the department, in writing, or by telephone call to the enrollment broker's toll-free member telephone line. Enrollment changes are effective no later than the first day of the second month beginning after the date on which the enrollment broker receives the enrollee's written or verbal request.

d. Ongoing enrollment. Enrollees shall remain enrolled with the chosen MCP for a total of 12 months.

e. Enrollment cycle. Prior to the end of the enrollee's annual enrollment period, the enrollee will be notified of the option to maintain enrollment with the current MCP or to enroll with a different MCP.

73.3(4) Benefit reimbursement prior to enrollment.

a. Prior to the effective date of MCP enrollment, except as provided in paragraph 73.3(4) "b," the department will reimburse providers for covered program benefits pursuant to 441—Chapters 74 through 91, as applicable for eligible members.

b. The MCP shall be responsible for covering newly retroactive Medicaid eligibility periods prior to the effective date of enrollment for babies born to Medicaid-enrolled women who are retroactively eligible to the month of birth.

[ARC 0312D, IAB 5/27/26, effective 7/1/26]

441—73.4(249A) Disenrollment process.

73.4(1) Enrollee-requested disenrollment. An enrollee may request disenrollment with an MCP as follows:

a. During the first 90 days following the date of the enrollee's initial enrollment with the MCP, the enrollee may request disenrollment, for any reason, in writing or by a telephone call to the enrollment broker's toll-free member telephone line.

b. After the 90 days following the date of the enrollee's enrollment with the MCP, when an enrollee is requesting disenrollment due to good cause, the enrollee member shall first make a verbal or written filing of the issue through the MCP's grievance system. If the member does not experience resolution, the MCP shall direct the member to the enrollment broker. The enrolled member may request disenrollment in writing or by a telephone call to the enrollment broker's toll-free member telephone line and must request a good-cause change for enrollment. Good-cause changes include the following:

(1) The MCP does not, because of moral or religious objections, cover the service the member seeks.

(2) The member needs related services to be performed at the same time, not all related services are available within the network, and the member's primary care provider or another provider determines that receiving the services separately would subject the member to unnecessary risk.

(3) Other reasons, including but not limited to poor quality of care, lack of access to services covered under the contract, lack of access to providers experienced in dealing with the member's

health or dental care needs, or eligibility and choice to participate in a program not available in managed care (for example, PACE).

c. The final decision for disenrollment will be determined by the department.

73.4(2) *Disenrollment by department.* Disenrollment will occur when:

a. The contract between the department and the MCP is terminated.

b. The enrollee becomes ineligible for Medicaid, the hawki program, IHAWP, or the dental wellness plan. If the enrollee becomes ineligible and is later reinstated to these programs, enrollment in the MCP will also be reinstated.

c. The enrollee transfers to an eligibility group excluded from managed care plan enrollment.

d. The department has determined that participation in HIPP as described in 441—Chapter 75 is more cost-effective than enrollment in managed health care.

e. The enrollee dies.

f. The enrollee has changed residence to another state.

73.4(3) *Managed care plan-requested disenrollment.* An MCP shall not disenroll an enrollee or encourage an enrollee to disenroll for any reason, including the enrollee's health or dental care needs or change in health or dental care status or because of the enrollee's utilization of medical services, diminished capacity, or uncooperative or disruptive behavior resulting from the enrollee's special needs. The only exception is when the MCP can document and provide conclusive evidence to the department that the enrollee's continued enrollment seriously impairs the MCP's ability to furnish services to either this particular enrollee or other enrollees. The MCP shall have a multi-level verification process by which the department is assured that disenrollment is not requested for another reason.

73.4(4) *Disenrollment effective date.*

a. The effective date of a department-approved disenrollment will be no later than the first day of the second calendar month beginning after the month in which:

(1) The enrollee requests disenrollment;

(2) The department notifies the enrollee and MCP of disenrollment; or

(3) The MCP requests disenrollment.

b. The enrollee shall remain enrolled in the MCP and the MCP will be responsible for services covered under the contract until the effective date of disenrollment unless the enrollee is in an inpatient setting at the time of disenrollment. If the enrollee is in an inpatient setting at the time of disenrollment, the MCO shall be responsible for the inpatient services for 60 days or until the enrollee is discharged.

[ARC 0312D, IAB 5/27/26, effective 7/1/26]

441—73.5(249A) MCP covered services.

73.5(1) *Required services—MCOs.* An MCO shall provide:

a. For all enrolled members, services as set forth in 441—Chapters 78, 81, 82, 83, 84, 85, and 87, with the exception of the following:

(1) Area education agency services.

(2) Dental services not provided in an outpatient hospital setting.

(3) Infant and toddler program services.

(4) Local education agency services.

(5) State of Iowa veterans home services.

(6) Money Follows the Person (MFP) Rebalancing Demonstration Grant-funded services.

b. For IHAWP enrolled members, services as set forth in 441—Chapter 74.

c. For hawki enrolled members, services as set forth in 441—Chapter 86.

73.5(2) *Community-based case management service.* The MCO is required to provide services that meet requirements specified in the contract.

73.5(3) Value-added services. An MCP may develop optional services and supports to address the needs of enrollees. These services and supports shall be implemented only after approval by the department.

73.5(4) Required services—PAHPs. A PAHP shall provide services to enrollees under the contract with the department and on the basis of prepaid capitation payments or other payment arrangements that do not use state plan payment rates. PAHPs shall provide:

a. For enrollees other than IHAWP enrollees and hawki program enrollees, services as set forth in 441—Chapters 73, 74, 78, and 88, with the exception of the following:

- (1) Area education agency services.
 - (2) Inpatient hospital or institutional services.
 - (3) Advance directive requirements in dental nonclinical services, such as transportation.
 - (4) Long-term care (skilled nursing facilities, intermediate care facilities, residential care facilities, the Woodward state resource center, or ICFs/ID).
 - (5) Inpatient psychiatric care provided at the state-administered mental health institutes.
 - (6) Services provided at specialized adolescent psychiatric facilities.
 - (7) Day treatment and partial hospitalization services for persons aged 20 or under.
 - (8) Enhanced services provided to certain eligible recipients.
- b.* For IHAWP enrolled members, services as set forth in 441—Chapter 74.
- c.* For hawki enrolled members, services as set forth in 441—Chapter 86.

[ARC 0312D, IAB 5/27/26, effective 7/1/26]

441—73.6(249A) Amount, duration and scope of services.

73.6(1) The MCP shall provide, at a minimum, all benefits and services deemed medically necessary that are covered under the contract with the department. In accordance with federal funding requirements, including 42 CFR 438.210(a)(3), the MCP shall furnish covered services in an amount, duration and scope reasonably expected to achieve the purpose for which the services are furnished. The MCP shall not arbitrarily deny or reduce the amount, duration and scope of a required service solely because of diagnosis, type of illness, or condition of the enrollee. With the exception of court-ordered services, as a condition of payment, the MCO shall provide prior authorization for any admissions to an NF, an ICF/ID, a psychiatric medical institution for children (PMIC), and a state-administered mental health institute. Prior MCO approval is also required for all out-of-state placements.

73.6(2) The MCP may place appropriate limits on services on the basis of medical necessity criteria for the purpose of utilization management, provided the services can reasonably be expected to achieve their purpose in accordance with the contract. The MCP shall not:

- a.* Avoid costs for services covered in the contract by referring members to publicly supported health or dental care resources.
- b.* Deny reimbursement of covered services based on the presence of a preexisting condition.

73.6(3) The MCP shall allow each enrollee to choose a health or dental professional, to the extent possible and appropriate, within the MCP's provider network. The MCP shall ensure compliance with the Americans with Disabilities Act (ADA) as amended to July 1, 2026, in the delivery and approval of all services.

[ARC 0312D, IAB 5/27/26, effective 7/1/26]

441—73.7(249A) Emergency services.

73.7(1) Emergency services shall be available 24 hours a day, seven days a week.

73.7(2) In accordance with federal funding requirements, including 42 CFR 438.114, the MCP shall:

- a.* Cover emergency services without the need for prior authorization and shall not limit reimbursement to network providers.
- b.* Cover and pay for emergency services regardless of whether the provider that furnishes the services is enrolled with Iowa Medicaid or has a contract with the MCP.

c. Pay noncontracted providers for emergency services the amount that would have been paid if the service had been provided under the state's fee-for-service Medicaid program.

d. Cover the medical screening examination provided to a member who presents to an emergency department with an emergency medical condition. This requirement applies to MCOs only.

73.7(3) The MCP shall not deny payment for:

a. Treatment obtained when an enrollee has an emergency medical condition.

b. Treatment obtained when a representative of the MCP instructs the enrollee to seek emergency medical services.

[ARC 0312D, IAB 5/27/26, effective 7/1/26]

441—73.8(249A) Access to service.

73.8(1) The MCP shall ensure enrollees have access to services as specified in the contract. The MCP shall provide available, accessible, and adequate numbers of institutional facilities, service locations, and service sites and professional, allied, and paramedical personnel for the provision of covered services, including all emergency services, on a 24-hours-a-day, seven-days-a-week basis. At a minimum, access to services shall comply with the standards described in the contract. For areas of the state where provider availability is insufficient to meet these standards, for example, in health or dental professional shortage areas and medically underserved areas, the access standards shall meet the usual and customary standards for the community. Exceptions to the requirements contained in this rule shall be justified and documented to the state on the basis of community standards. All other services not specified in this rule shall meet the usual and customary standards for the community.

73.8(2) Choice of providers. An enrollee shall use the MCP's provider network unless the MCP has authorized a referral to a nonparticipating provider for provision of a service or treatment plan or as specified for provision of emergency services set forth in rule 441—73.7(249A). In accordance with federal funding requirements, including 42 CFR 431.51(b)(2), the MCO shall allow enrollees freedom of choice of providers of any department-enrolled family planning service provider including those providers that are not in the MCP network.

73.8(3) Continuity of care. The MCP shall have policies and procedures that provide for the continuity of care of treatment to ensure that a new enrollee's existing services are honored as required in the contract.

73.8(4) Adequate service referral support and after-hours call-in coverage. The MCP shall ensure enrollee access to service information and medical coverage 24 hours a day, 7 days a week, 365 days a year.

a. *Member helpline.* The MCP shall maintain a dedicated toll-free enrollee services helpline as established in the contract to handle a variety of member inquiries and to provide warm transfer of enrollees to outside entities, such as provider offices, and to internal MCP departments, such as care coordinators.

b. *Nurse call line.* The MCO shall operate a toll-free nurse call line that provides nurse triage telephone services for members to receive medical advice 24 hours a day, seven days a week from trained medical professionals.

73.8(5) The MCP shall ensure that network providers are responsible for providing preventive and primary health or dental care to the enrollee. Primary care providers shall initiate referrals for specialist care, where appropriate, and maintain the continuity of patient care. Primary care providers may be physicians, advanced registered nurse practitioners, or physician associates, licensed and practicing in accordance with state law.

[ARC 0312D, IAB 5/27/26, effective 7/1/26]

441—73.9(249A) Incident reporting.

73.9(1) The MCO shall develop and implement a critical incident reporting and management system for participating providers in accordance with the department requirements for reporting

incidents for Section 1915(c) HCBS waivers; for the Section 1915(i) habilitation program; and as required for licensure of programs through the department of inspections, appeals, and licensing.

73.9(2) The MCO shall develop and implement policies and procedures, subject to department review and approval, to:

- a. Address and respond to incidents;
- b. Report incidents to the appropriate entities in accordance with required time frames; and
- c. Track and analyze incidents.

[ARC 0312D, IAB 5/27/26, effective 7/1/26]

441—73.10(249A) Discharge planning. The MCO shall establish policies and procedures, subject to approval by the department, that protect an enrollee from involuntary discharge that may lead to placement in an inappropriate or more restrictive setting. The MCO shall facilitate a seamless transition whenever an enrollee transitions between facilities or residences.

[ARC 0312D, IAB 5/27/26, effective 7/1/26]

441—73.11(249A) Level of care (LOC) assessment.

73.11(1) The department will retain full authority to determine whether the Medicaid LOC or needs-based assessment has been completed in a timely manner by the appointed vendor. The MCO will be notified once an enrolled member's LOC determination has been completed. The LOC and needs-based eligibility assessment process and the requirements are provided in 441—Chapters 75, 78, 81, 82, 83, and 85. HCBS waiver LOC determinations must be consistent with those made for the appropriate institutional LOC under the state plan.

73.11(2) At any time, if the MCO becomes aware the enrollee's functional or medical status has changed in a way that may affect LOC or needs-based eligibility, the MCO shall submit documentation to the department's appointed vendor to conduct an LOC or needs-based assessment. The department-approved tools shall be used to conduct an updated assessment. The updated assessment shall then be submitted to the department for determination of LOC or needs-based eligibility.

[ARC 0312D, IAB 5/27/26, effective 7/1/26]

441—73.12(249A) Appeal of MCP actions. The MCPs shall have written first-level appeal policies and procedures for an enrollee, or an enrollee's authorized representative, to appeal an MCP action. The policies must address contractual requirements and federal funding requirements, including 42 CFR 438, Subpart F.

73.12(1) MCP appealable actions. MCP actions that may be appealed by an enrollee may include, as cited in 42 CFR 438.400(b):

- a. Denial or limited authorization of a requested service, including the type or level of service.
- b. Reduction, suspension, or termination of a previously authorized service.
- c. Denial, in whole or in part, of payment of service.
- d. Failure to provide services in a timely manner as described by the department.
- e. Failure to act within the required time frames set forth in federal funding requirements, including 42 CFR 438.408(b).
- f. Denial of an enrollee's request to exercise the enrollee's right to obtain services outside of the MCP's network related to rural access or capacity.
- g. Denial of an enrollee's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other enrollee financial liabilities.

73.12(2) Appeal process. The MCP first-level appeal process will be approved by the department and shall:

- a. Allow for the appeal request to be submitted in writing or verbally.
- b. Require acknowledgment of the receipt of a request for an appeal within three working days.
- c. Allow for participation by the enrollee and the provider.

d. Provide for resolution of nonexpedited appeals to be concluded within 30 calendar days of receipt of the request unless an extension is requested.

e. Provide for resolution of expedited appeals where the standard time period could seriously jeopardize the member's health or ability to maintain or regain maximum function to be within 72 hours of receipt of the notice pursuant to federal funding requirements, including 42 CFR 438.402.

f. Ensure that the review will be made by qualified professionals who were not involved with the original action.

g. Ensure issuance of a notice of decision for each appeal. These notices shall contain the member's appeal rights with the department and shall contain an adequate explanation of the action taken and the reason for the decision.

[ARC 0312D, IAB 5/27/26, effective 7/1/26]

441—73.13(249A) Appeal to department. If the enrollee is not satisfied with the final decision rendered by the MCP through the MCP's first-level appeal process, the enrollee may file an appeal with the department. This process is referred to as a state fair hearing, an action in accordance with the appeal process available to all persons receiving Medicaid-funded services as set forth in 441—Chapter 2506 and federal requirements for a state fair hearing in 42 CFR 438.408(f).

[ARC 0312D, IAB 5/27/26, effective 7/1/26]

441—73.14(249A) Continuation of benefits. The MCP shall be required to continue the member's benefits during any appeal in accordance with federal funding requirements, including 42 CFR 438.420.

73.14(1) If the benefits are continued or reinstated while the appeal is pending, the benefits must be continued until one of the following occurs:

a. The enrollee withdraws the appeal request;

b. Ten calendar days pass after the MCP mailed the notice providing the resolution of the appeal against the enrollee unless the enrollee, within the ten-calendar-day time frame, requests a state fair hearing with continuation of benefits until a state fair hearing decision is reached; or

c. The time period or service limits of a previously authorized service are met.

73.14(2) If the final resolution of the state fair hearing is adverse to the enrollee, that is, it upholds the MCP's action, the MCP may recover the cost of the services furnished to the enrollee while the appeal was pending, to the extent services were furnished solely because of the requirements to maintain benefits during the appeal.

73.14(3) If the MCP or state fair hearing administrative law judge (ALJ) reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the MCP must authorize and provide the disputed services promptly and as expeditiously as the member's health or dental condition requires. If the MCP or the state fair hearing ALJ reverses a decision to deny authorization of services and the enrollee received the disputed services while the appeal was pending, the MCP must pay for these services.

[ARC 0312D, IAB 5/27/26, effective 7/1/26]

441—73.15(249A) Grievances. The MCP shall have policies and procedures for reviewing expressions of dissatisfaction about any matter other than an adverse benefit determination. Grievances may include but are not limited to quality of care or services provided, aspects of interpersonal relations such as rudeness of a provider or employee, or failure to respect the enrollee's rights regardless of whether remedial action is requested pursuant to 42 CFR 438.400(b). Grievances may be communicated verbally or in writing and require that the review be conducted by someone other than the person or persons involved in the grievance. All policies related to the review of grievances shall be approved by the department prior to implementation.

[ARC 0312D, IAB 5/27/26, effective 7/1/26]

441—73.16(249A) Written record. All MCP enrollee appeals and grievances shall be logged and reported to the department. The log shall include the status and resolution of all appeals and grievances pursuant to 42 CFR 438.416.

[ARC 0312D, IAB 5/27/26, effective 7/1/26]

441—73.17(249A) Information concerning procedures relating to the review of MCP decisions and actions. The MCP's written procedures for the review of MCP's decisions and actions shall be provided to each new enrollee in a member handbook, to participating providers in a provider manual, and to nonparticipating providers upon request.

[ARC 0312D, IAB 5/27/26, effective 7/1/26]

441—73.18(249A) Records and reports.

73.18(1) *Records system.* The MCPs shall document and maintain clinical and fiscal records in accordance with federal and state requirements, including 441—Chapter 79 and 42 CFR 456, throughout the course of the contract. The records system shall:

- a. Identify transactions with or on behalf of each enrollee by the state identification number assigned to the enrollee by the department.
- b. Provide a rationale for, and documentation of, decisions made by the MCP based upon medical necessity.
- c. Permit effective professional review for medical audit processes.
- d. Facilitate an adequate system for monitoring treatment reimbursed by the MCO, including follow up of the implementation of discharge plans and referral to other providers.

73.18(2) *Content of individual treatment record.* The MCP shall ensure that participating providers maintain an adequate recordkeeping system that includes a complete medical, dental, or service record for each enrolled member including documentation of all services provided to each enrollee in compliance with the contract and provisions of 441—Chapter 79 and pursuant to federal funding requirements, including 42 CFR 456. MCOs shall require use of an EVV system for personal care services.

73.18(3) *Confidentiality of health care, mental health care, and substance abuse information.* The MCP shall protect and maintain the confidentiality of all protected health information by implementing policies for staff and through contract terms with participating providers. The policies must comply with applicable state and federal laws.

73.18(4) *EVV system.* The MCO will participate in EVV planning activities and use the MCO-proposed, department-approved EVV system that will be in place within a time frame determined by the department to ensure compliance with state and federal regulations, including Section 12006 of the Cures Act (42 U.S.C. §1396b(1) as amended to July 1, 2026). Beginning on the dates required by the department, the MCO shall require personal care providers and home health services to use the MCO EVV system or another EVV system complying with Section 12006 of the Cures Act as amended to July 1, 2026. The MCO shall develop and describe what methodologies will be used to monitor member receipt and utilization of personal care, home health services, and other services using the EVV system. All EVV data that originates in or passes through the MCO EVV system will be provided to the department in a format and time frame subject to department approval.

[ARC 0312D, IAB 5/27/26, effective 7/1/26]

441—73.19(249A) Audits. The department or its designee and the U.S. Department of Health and Human Services (HHS) may evaluate through inspections or other means the quality, appropriateness, and timeliness of services performed by the MCP. The department or HHS may audit and inspect any records of an MCP, or the subcontractor of the MCP, that pertain to services performed and the determination of amounts paid under the contract. These records will be made available at times, at places, and in a manner as authorized representatives of the department or its designee as HHS may request.

[ARC 0312D, IAB 5/27/26, effective 7/1/26]

441—73.20(249A) Marketing. MCP marketing activities and materials shall comply with applicable laws and regulations regarding marketing by the MCP and contract terms. The department will approve all marketing materials, which must comply with federal funding requirements, including 42 CFR 438.10 and 42 CFR 438.104.

[ARC 0312D, IAB 5/27/26, effective 7/1/26]

441—73.21(249A) Enrollee education.

73.21(1) *Use of services.* The MCP shall provide written information to all enrollees on the use of the services the MCP is responsible to arrange, monitor, and reimburse. Information must include the array of services covered; how to access covered services; the providers participating; an explanation of the process for the review of MCP decisions and actions, including the enrollee's right to a fair hearing under 441—Chapter 2506; how to access the state fair hearing process; provision of after-hours and emergency care; procedures for notifying enrollees of a change in benefits or office sites; how to request a change in providers; a statement of consumer rights and responsibilities; out-of-area use of service information; availability of toll-free telephone information and crisis assistance; and the appropriate use of the referral system.

73.21(2) *Outreach to members with special needs.* The MCP shall provide enhanced outreach to members with special needs, including but not limited to persons with a psychiatric disability, an intellectual disability or other cognitive impairments; illiterate persons; non-English-speaking persons; and persons with visual impairments or who are deaf or hard of hearing.

73.21(3) *Patient rights and responsibilities.* The MCP shall have in effect a written statement of patient rights and responsibilities that is available upon request as well as issued to all new enrollees. This statement shall be part of the packet of enrollment information provided to all new enrollees.

[ARC 0312D, IAB 5/27/26, effective 7/1/26]

441—73.22(249A) Payment to the MCP.

73.22(1) *Capitation rate.* In consideration for all services rendered by an MCP under a contract with the department, the MCP will receive a payment each month for each enrolled member. The monthly reimbursement may be reduced by amounts withheld for pay-for-performance components of the contract. The withheld amounts will be distributed based on the terms described in the MCP contract. Additionally, the department will make an allowance for obligations resulting from Section 9010 of the Patient Protection and Affordable Care Act as amended to July 1, 2026, regarding the health insurance provider's fee. This capitation rate, inclusive of the amounts withheld and the health insurance provider's fee, represents the total obligation of the department with respect to the costs of medical care and services provided to enrolled members under the contract, except as otherwise designated in the contract rate. Pay-for-performance terms will allow for incentive reimbursement if the MCP meets metrics described in the MCP contract.

73.22(2) *Determination of rate.* The actuarially sound capitation rate will be determined according to the terms of federal funding requirements, including 42 CFR 438.6, Actuarial Standards of Practice 49, as amended to July 1, 2026, and other related CMS regulations and generally accepted actuarial principles and practices.

73.22(3) *Third-party liability.* If an enrolled member has health insurance coverage or a responsible party other than the Medicaid program available for payment of medical or dental expenses, it is the right and responsibility of the MCP to investigate these third-party resources and attempt to obtain payment.

a. The MCP shall have a time limit determined by the department to attempt to collect from third-party resources.

b. The MCP shall retain all funds collected from third-party resources during the time limit.

c. A complete record of all third-party collections must be maintained and made available to the department on request.

d. In the event that the MCP no longer contracts with the department, the department has the right to seek recovery of any third-party collections not collected by the time the contract ends and retain the funds. This includes but is not limited to subrogation cases.

e. The department has the right to retain all funds collected from third-party resources after the MCP time limit.

73.22(4) Medical loss ratio. The MCP shall report the experienced medical loss ratio for each contract rate period. In the event that the medical loss ratio falls below the department-designated target, the department shall recoup excess capitation paid to the MCP.

[ARC 0312D, IAB 5/27/26, effective 7/1/26]

441—73.23(249A) Claims payment by the MCP.

73.23(1) The MCOs shall pay or deny:

- a.* Ninety percent of all clean claims within 30 calendar days of receipt,
- b.* Ninety-nine point five percent of all clean claims within 90 calendar days of receipt, and
- c.* Ninety-five percent of all claims within 45 calendar days of receipt.

73.23(2) The PAHP shall pay or deny:

- a.* Ninety percent of all clean claims within 14 calendar days of receipt,
- b.* Ninety-nine percent of all clean claims within 90 calendar days of receipt, and
- c.* Ninety-five percent of all claims within 21 calendar days of receipt.

73.23(3) Managed care limits on payment responsibility for services.

a. The MCP is not required to reimburse providers for the provision of services that do not meet the criteria of medical necessity.

b. The MCP has the right to require prior authorization of covered services and to deny reimbursement to providers that do not comply with such requirements.

c. Payment responsibilities for emergency room services are as provided in rule 441—73.7(249A).

73.23(4) Payment to nonparticipating providers. In reimbursing nonparticipating providers, the MCO is obligated to pay 80 percent of the payment to participating providers.

73.23(5) Timely filing. The in-network provider filing limit shall be no more than 180 days from the date of service.

[ARC 0312D, IAB 5/27/26, effective 7/1/26]

441—73.24(249A) Quality assurance. The MCP shall have in effect an internal quality assurance and performance improvement system that meets the requirements of any or all applicable state and federal laws.

[ARC 0312D, IAB 5/27/26, effective 7/1/26]

441—73.25(249A) Certifications and program integrity. The MCP shall develop and implement policies, procedures, and a mandatory compliance plan to ensure compliance with the contract requirements for certification, program integrity and prohibited affiliations. The MCP shall cooperate and collaborate with the department on all program integrity activities. The MCP shall comply with state and federal laws pertaining to these requirements, including 42 CFR 438.608 and 42 CFR 455.

[ARC 0312D, IAB 5/27/26, effective 7/1/26]

These rules are intended to implement Iowa Code section 249A.4.

[Filed Emergency After Notice ARC 2358C (Notice ARC 2241C, IAB 11/11/15), IAB 1/6/16,
effective 1/1/16]

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[Filed ARC 0312D (Notice ARC 9853C, IAB 12/24/25), IAB 5/27/26, effective 7/1/26]

CHAPTER 74
IOWA HEALTH AND WELLNESS PLAN

Chapter rescission date pursuant to Iowa Code section 17A.7: 7/1/31

441—74.1(249A,249N) Definitions. The following definitions apply to this chapter in addition to the definitions in 441—Chapter 75.

“*Caretaker*” means the same as defined in rule 441—75.1(249A).

“*Countable income*” means “modified adjusted gross income” (MAGI) or “household income,” as applicable, determined pursuant to 42 U.S.C. §1396a(e)(14) as amended to July 1, 2026.

“*Enrollment period*” means the period of time for which Iowa health and wellness plan eligibility is established.

“*Essential health benefits*” means the essential health benefits defined at 42 U.S.C. §18022 as amended to July 1, 2026.

“*Iowa dental wellness plan*” means the managed care dental benefit program set forth in 441—Chapter 73.

“*Iowa health and wellness plan*” or “*IHAWP*” means the medical assistance program set forth in this chapter for individuals with countable income that does not exceed 133 percent of the federal poverty level (FPL).

“*Iowa wellness plan*” means the benefits and services provided to IHAWP members.

“*Managed care organization*” or “*MCO*” means an entity that (1) is under contract with the department to provide services to Medicaid recipients and (2) meets the definition of “health maintenance organization” as defined in Iowa Code section 514B.1.

“*Medical assistance*” or “*Medicaid*” means payment of all parts of the cost of the care and services made in accordance with Title XIX of the Federal Social Security Act as amended to July 1, 2026.

“*Medically exempt individual*” means an individual exempt from mandatory enrollment in an alternative benefit plan pursuant to 42 CFR 440.315 as amended to July 1, 2026.

“*Minimum essential coverage*” means health insurance defined in Section 5000A(f) of Subtitle D of the Internal Revenue Code as amended to July 1, 2026.

“*Prepaid ambulatory health plan*” or “*PAHP*” has the meaning set forth in 42 CFR 438.2 as amended to July 1, 2026.

“*Qualified employer-sponsored coverage*” is defined pursuant to 42 U.S.C. §1396e1(b) as amended to July 1, 2026.

[ARC 0313D, IAB 5/27/26, effective 7/1/26]

441—74.2(249A,249N) Eligibility factors. Except as more specifically provided in this chapter, IHAWP eligibility will be determined according to the requirements of 441—Chapter 75.

74.2(1) Persons covered. Subject to the additional requirements of this chapter and of 441—Chapter 75, medical assistance under IHAWP will be available to persons 19 through 64 years of age who:

- a. Are not eligible for medical assistance in a mandatory group under 441—Chapter 75;
- b. Have countable income at or below 133 percent of the FPL for their household size;
- c. Are not entitled to or enrolled in Medicare benefits under Part A or Part B of Title XVIII of the Social Security Act as amended to July 1, 2026; and
- d. Are not pregnant at the time of application or reenrollment.

74.2(2) Parents or caretakers of dependent children. All children under the age of 21 living with a parent or caretaker who will be claimed as a dependent by the parent or caretaker for state or federal income tax purposes must be enrolled in Medicaid, in the Children’s Health Insurance Program (CHIP), or in other minimum essential coverage as a condition of the parent’s or caretaker’s eligibility for IHAWP benefits.

74.2(3) *Citizenship.* To be eligible for IHAWP benefits, a person must meet the citizenship requirements in 441—Chapter 75.

[ARC 0313D, IAB 5/27/26, effective 7/1/26]

441—74.3(249A,249N) *Application.* Medicaid application policies and procedures described in 441—Chapter 76 apply to applications for IHAWP.

[ARC 0313D, IAB 5/27/26, effective 7/1/26]

441—74.4(249A,249N) *Financial eligibility.*

74.4(1) *Countable income.* Individuals are financially eligible for IHAWP if their countable income is no more than 133 percent of the FPL as of the date of a decision on initial or ongoing eligibility.

74.4(2) *Household size.* For financial eligibility purposes, household size will be determined according to the MAGI methodology.

[ARC 0313D, IAB 5/27/26, effective 7/1/26]

441—74.5(249A,249N) *Enrollment period.*

74.5(1) *Effective dates of eligibility.* IHAWP eligibility will be effective on the first day of the month of application or the first day of the month all eligibility requirements are met, whichever is later. The enrollment period will continue for 12 consecutive months unless the member is disenrolled in accordance with the provisions of rule 441—74.8(249A,249N).

74.5(2) *Reinstatement.* Enrollment for IHAWP may be reinstated without a new application in accordance with 441—Chapter 76.

74.5(3) *Presumptive eligibility.* The enrollment period of 12 consecutive months will not apply to individuals temporarily enrolled in Medicaid based on a presumptive eligibility determination by a qualified entity in accordance with 441—Chapter 76.

74.5(4) *Retroactive enrollment.* Medical assistance will be available to a pregnant woman or an infant (under one year of age), or a resident of a nursing facility licensed under Iowa Code chapter 135C, for all or any of the three months preceding the month in which an application is filed when eligibility requirements are met in accordance with 441—Chapter 76.

[ARC 0313D, IAB 5/27/26, effective 7/1/26]

441—74.6(249A,249N) *Reporting changes.*

74.6(1) *Reporting requirements.* In addition to the reporting requirements in 441—Chapter 76, as a condition of ongoing enrollment, a member shall report any of the following changes no later than ten calendar days after the change takes place:

- a. The member enters a nonmedical institution, including but not limited to a penal institution.
- b. The member abandons Iowa residency.
- c. The member turns 65.
- d. The member becomes entitled to or enrolled in Medicare Part A or Part B or both.
- e. A child under the age of 21 living with the member loses minimum essential coverage if the member is the child's parent or caretaker and will claim the child as a dependent for state or federal income tax purposes.
- f. The member is pregnant.

74.6(2) *Untimely report.* When a change is not timely reported as required by this rule, any program expenditures for care or services provided when the member was not eligible will be considered an overpayment and be subject to recovery from the member in accordance with 441—Chapters 75 and 11. Program expenditures may include but are not limited to premiums and capitation payments.

74.6(3) *Effective date of change.* After enrollment, changes reported during the month that affect the member's eligibility will be effective the first day of the next calendar month unless:

- a. Timely notice of adverse action is required as specified in rule 441—16.2(17A); or

b. The enrollment period has expired and the member is not eligible for a new enrollment period.

[ARC 0313D, IAB 5/27/26, effective 7/1/26]

441—74.7(249A,249N) Reenrollment. A new eligibility determination is required to establish an enrollment period. The reenrollment process will follow the requirements in 441—Chapter 76.

[ARC 0313D, IAB 5/27/26, effective 7/1/26]

441—74.8(249A,249N) Terminating enrollment. IHAWP enrollment ends when any of the following occurs:

1. The enrollment period ends and coverage for the next enrollment period has not been renewed.
2. The member becomes eligible for medical assistance in a mandatory coverage group under 441—Chapter 75.
3. The member is found to have been ineligible for any reason.
4. The member dies.
5. The member turns 65.
6. The member abandons Iowa residency.
7. The member becomes entitled to or enrolled in Medicare Part A or Part B or both.
8. A child under the age of 21 living with the member loses minimum essential coverage, if the member is the child's parent or caretaker and will claim the child as a dependent for state or federal income tax purposes.
9. The member's countable income exceeds 133 percent of the FPL.
10. IHAWP is discontinued according to the requirements in rule 441—74.14(249A,249N).
11. The member does not pay monthly contributions as required by subrule 74.11(2).

[ARC 0313D, IAB 5/27/26, effective 7/1/26]

441—74.9(249A,249N) Recovery. The department will recover from a member all Medicaid funds incorrectly expended on behalf of the member in accordance with 441—Chapter 75.

74.9(1) The department will recover Medicaid funds expended on behalf of a member from the member's estate in accordance with 441—Chapter 75.

74.9(2) Funds received from third parties, including Medicare, by a provider other than a state mental health institute shall be reported to the department or the MCO, and an adjustment will be made to a previously submitted claim.

[ARC 0313D, IAB 5/27/26, effective 7/1/26]

441—74.10(249A,249N) Right to appeal.

74.10(1) Decisions and actions by the department regarding eligibility or services provided under this chapter may be appealed to the extent permitted by 441—Chapter 2506.

74.10(2) Members will not be entitled to an appeal hearing if the sole basis for denying or limiting services is discontinuance of the program pursuant to rule 441—74.14(249A,249N).

[ARC 0313D, IAB 5/27/26, effective 7/1/26]

441—74.11(249A) Financial participation.

74.11(1) Copayment. Payment for nonemergency use of a hospital emergency department shall be subject to an \$8 copayment by the member, which will be subtracted from the IHAWP payment otherwise due to the provider.

74.11(2) Monthly contributions. Members enrolled in the IHAWP with household income at or above 50 percent of the FPL are required to pay monthly contributions pursuant to this rule.

a. *Monthly contribution amount.* The monthly contribution amount for each member is based on the countable income of the member's household, determined pursuant to 441—Chapter 75, as a percentage of the FPL for the household. Monthly contribution amounts are as follows:

- (1) For a member with household income between 50 and 100 percent of the FPL, \$5;

(2) For a member with household income above 100 percent of the FPL, \$10.

b. Waiver during the first year of enrollment. The monthly contribution will be waived during the member's first 12 months of continuous enrollment.

c. Monthly contribution exemptions. A member shall be exempt from monthly contribution payments when any of the following circumstances apply:

(1) The member completed healthy behaviors pursuant to subrule 74.11(4) in the previous enrollment period.

(2) The member is determined by the department to be a medically exempt individual pursuant to subrule 74.12(2).

(3) The member has access to cost-effective, employer-sponsored coverage and is enrolled in the health insurance premium payment program pursuant to 441—Chapter 75.

(4) The member is exempt from premiums pursuant to 42 CFR 447.56(a)(1)(x) as amended to July 1, 2026, as an Indian who is eligible to receive or has received an item or service furnished by an Indian health care provider or through referral under contract health services.

(5) The member claims a hardship exemption indicating that payment of the monthly contribution will be a financial hardship. The member may claim a hardship exemption by telephoning Iowa Medicaid member services, by checking the hardship box on the billing statement (for the month of the billing statement), or by submitting a written statement to the address designated by the department. The member's hardship exemption must be received or postmarked within five working days after the monthly contribution due date. If the hardship exemption request is not made in a timely manner, the exemption shall not be granted. Members must complete the process in every month for which they wish to claim financial hardship. There is no limit to the number of hardship exemptions for which a member may apply.

d. Billing and payment. An Iowa Medicaid billing statement form will be used for billing and collection of the monthly contribution.

(1) Method of payment. Members shall submit contribution payments to the address specified by the department. Members can also submit contributions through the department's website.

(2) Due date. When the department notifies a member of the amount of the monthly contribution, the member shall pay any monthly contributions due in accordance with the following:

1. The monthly contribution is due on the fifteenth day of the month in which the statement is received.

2. If the fifteenth day of the month falls on a weekend or state or federal holiday, payment is due on the first working day following the weekend or holiday.

3. Monthly contribution payments must be received or postmarked by the due date.

(3) Application of payment. The department will apply monthly contribution payments received to the oldest unpaid month in the current enrollment period. When monthly contributions for all months in the enrollment period have been paid, the department will hold any excess and apply it to any months for which eligibility is subsequently established.

e. Failure to pay monthly contributions.

(1) An IHAWP member with household income between 50 and 100 percent of the FPL who fails to pay the assessed monthly contribution and who does not qualify for a monthly contribution exemption pursuant to subrule 74.11(2) shall owe the monthly contribution to the department as an unpaid premium subject to recovery in accordance with 441—Chapter 75. A member shall have no less than 90 days from the due date to pay any unpaid monthly contribution before the unpaid amount shall be subject to recovery.

(2) An IHAWP member with household income above 100 percent of the FPL who fails to pay the assessed monthly contribution and who does not qualify for a monthly contribution exemption pursuant to subrule 74.11(2) will have the member's eligibility terminated. In addition, the member shall owe the monthly contribution to the department as an unpaid premium subject to recovery in accordance with 441—Chapter 75. A member shall have no less than 90 days from the due date to pay any unpaid monthly contribution before the unpaid amount shall be subject to recovery.

1. A member shall have no less than 90 days from the due date to pay any unpaid monthly contribution before eligibility will be terminated or the unpaid amount will be subject to recovery.

2. A member whose eligibility is terminated due to nonpayment of monthly contributions may reenroll for Medicaid benefits pursuant to 441—Chapter 76.

3. Unpaid premiums will not be considered a collectible debt by the state if, at the member's next annual renewal date, the member does not apply for renewed eligibility, and the member has no claims for services delivered after the month of the last premium payment.

f. Refund of monthly contributions.

(1) Monthly contributions paid may be refunded if the member qualified for a monthly contribution exemption pursuant to paragraph 74.11(2)“c” or when a member's IHAWP coverage is terminated for the following reasons:

1. The member is no longer eligible for coverage in IHAWP; or
2. The member dies.

(2) The amount of any refund will be offset by any outstanding monthly contributions owed.

(3) The refund will be paid within two calendar months from the date of termination from the program.

74.11(3) Aggregate annual limits on copayments and monthly contributions. The total aggregate annual amount of copayments and monthly contributions for an individual will not exceed 5 percent of the household's countable annual income determined pursuant to 441—Chapter 75.

74.11(4) Healthy behaviors. An IHAWP member who completes a wellness examination and health risk assessment during any enrollment year will have monthly contributions waived in the subsequent enrollment year.

a. Under healthy behaviors, a wellness examination may be related to either physical health or oral health. Physical examinations must be performed by a medical provider and must assess a member's overall physical health consistent with standard clinical guidelines for preventive physical examinations and as defined by the department. Oral examinations must be performed by a dental provider consistent with standard oral health guidelines for preventive dental examinations and as outlined in 441—Chapter 73.

b. A health risk assessment is an assessment offered by a managed care plan through which the member is receiving IHAWP benefits.

[ARC 0313D, IAB 5/27/26, effective 7/1/26]

441—74.12(249A) Benefits and service delivery. Covered benefits and the service delivery method will be determined by the member's health status.

74.12(1) Iowa wellness plan services. Members shall be enrolled in IHAWP unless the member is determined by the department to be a medically exempt individual.

a. Covered Iowa wellness plan services are essential health benefits; all other benefits required pursuant to 42 U.S.C. §1396u-7(b)(1)(B) as amended to July 1, 2026, including prescription drugs; and dental services consistent with 441—Chapter 78.

b. Members enrolled in IHAWP shall be subject to enrollment in managed care, other than a program for all-inclusive care for the elderly (PACE), pursuant to 441—Chapter 73.

c. Dental services will be provided under the Iowa dental wellness plan as set forth in 441—Chapter 73 through a contract with one or more dental prepaid ambulatory health plans. The dental prepaid ambulatory health plan shall provide the member with a dental card identifying the member as eligible for dental services.

74.12(2) Medically exempt individuals. An IHAWP member who has been determined by the department to be a medically exempt individual will be given the choice of the benefits and service delivery method provided by the Iowa wellness plan or receiving benefits and services pursuant to 441—Chapter 78.

a. A provider with a current national provider identifier number may refer a member for a medically exempt individual determination by submitting a completed form prescribed by the department.

b. Upon receipt of the appropriate forms, the department will determine whether the member qualifies as a medically exempt individual in accordance with 42 CFR 440.315 as amended to July 1, 2026.

74.12(3) *Qualified employer-sponsored coverage.* An individual who has access to cost-effective, employer-sponsored coverage shall be subject to enrollment in the health insurance premium payment program pursuant to 441—Chapter 75.

[ARC 0313D, IAB 5/27/26, effective 7/1/26]

441—74.13(249A,249N) Claims and reimbursement methodologies. Payment for services provided under the Iowa wellness plan services will be provided in accordance with 441—Chapter 79 or as provided in a contract between the department or the member's MCO and the provider.

[ARC 0313D, IAB 5/27/26, effective 7/1/26]

441—74.14(249A,249N) Discontinuance of program.

74.14(1) If the methodology for calculating the federal medical assistance percentage for eligible individuals, as provided in 42 U.S.C. §1396d(y) as amended to July 1, 2026, is modified through federal law or regulation, in a manner that reduces the percentage of federal assistance to the state, or if federal law or regulation affecting eligibility or benefits for IHAWP is modified, the department may implement an alternative plan as specified in the medical assistance state plan or waiver for coverage of the affected population, subject to prior, statutory approval of implementation of the alternative plan.

74.14(2) If the methodology for calculating the federal medical assistance percentage for eligible individuals, as provided in 42 U.S.C. §1396d(y) as amended to July 1, 2026, is modified through federal law or regulation resulting in a reduction of the percentage of federal assistance to the state below 90 percent but not below 85 percent, the medical assistance program reimbursement rates for inpatient and outpatient hospital services will be reduced by a like percentage in the succeeding fiscal year, subject to prior, statutory approval of implementation of the reduction.

[ARC 0313D, IAB 5/27/26, effective 7/1/26]

These rules are intended to implement Iowa Code chapters 249A and 249N.

[Filed Emergency After Notice ARC 1135C (Notice ARC 0972C, IAB 8/21/13), IAB 10/30/13, effective 10/2/13]

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CHAPTER 77
CONDITIONS OF PARTICIPATION FOR PROVIDERS
OF MEDICAL AND REMEDIAL CARE

[Prior to 7/1/83, Social Services[770] Ch 77]

[Prior to 2/11/87, Human Services[498]]

Chapter rescission date pursuant to Iowa Code section 17A.7: 7/1/31

441—77.1(249A) Physicians. All physicians (doctors of medicine and osteopathy) licensed to practice in the state of Iowa are eligible to participate in the program. Physicians in other states are also eligible if duly licensed to practice in that state.

[ARC 0314D, IAB 5/27/26, effective 7/1/26]

441—77.2(249A) Retail pharmacies. Retail pharmacies are eligible to participate if they meet the requirements of this rule.

77.2(1) Licensure. Participating retail pharmacies must be licensed in the state of Iowa or duly licensed in another state. Out-of-state retail pharmacies delivering, dispensing, or distributing drugs by any method to an ultimate user physically located in Iowa must be duly licensed by Iowa as a nonresident pharmacy for that purpose.

77.2(2) Survey participation. As a condition of participation, retail pharmacies are required to make available drug acquisition cost invoice information, product availability information if known, dispensing cost information, and any other information deemed necessary by the department to assist in monitoring and revising reimbursement rates pursuant to 441—subrule 79.1(8) or for the efficient operation of the pharmacy benefit.

a. A pharmacy shall produce and submit all requested information in the manner and format requested by the department or its designee at no cost to the department or its designee.

b. A pharmacy shall submit information to the department or its designee within the time frame indicated following receipt of a request for information unless the department or its designee grants an extension upon written request of the pharmacy.

c. Any dispensing or acquisition cost information submitted to the department that specifically identifies a pharmacy's individual costs will be held confidential.

[ARC 0314D, IAB 5/27/26, effective 7/1/26]

441—77.3(249A) Pharmacists. An authorized pharmacist licensed to practice in the state of Iowa is eligible to participate in the program.

[ARC 0314D, IAB 5/27/26, effective 7/1/26]

441—77.4(249A) Hospitals.

77.4(1) Qualifications. All hospitals licensed in the state of Iowa or in another state and certified as eligible to participate in Part A of the Medicare program (Title XVIII of the Social Security Act as amended to July 1, 2026) are eligible to participate in the medical assistance program, subject to the additional requirements of this rule.

77.4(2) Psychiatric bed tracking system. As a condition of participation in the medical assistance program, hospitals must establish procedures for participating in and updating the statewide psychiatric bed tracking system.

a. Definitions.

“*Adult beds*” means the number of staffed and available psychiatric beds ready for admission to individuals 18 years of age to 60 years of age.

“*Child beds*” means the number of staffed and available psychiatric beds ready for admission to individuals up to the age of 18.

“*Geriatric beds*” means the number of staffed and available psychiatric beds ready for admission to individuals 60 years of age and older.

“Hospital,” for purposes of this subrule, means any licensed hospital providing inpatient psychiatric services and the state mental health institutes.

“Psychiatric bed tracking system” means a web-based electronic system managed by the department that can be searched to locate inpatient psychiatric services at an Iowa hospital.

b. Hospitals are required to participate in the psychiatric bed tracking system.

c. Hospitals shall update the psychiatric bed tracking system, at a minimum, two times per day. The first update shall be entered between 12:00:01 a.m. and 9:59:59 a.m. each day; the second update shall be entered between 8:00:00 p.m. and 11:59:59 p.m. each day.

d. Each update must include the number of child beds by sex, the number of adult beds by sex, and the number of geriatric beds by sex.

e. Failure to comply with the psychiatric bed tracking reporting may result in sanctions in accordance with rule 441—79.2(249A).

[ARC 0314D, IAB 5/27/26, effective 7/1/26]

441—77.5(249A) Dentists. All dentists licensed to practice in the state of Iowa are eligible to participate in the program. Dentists in other states are also eligible if duly licensed to practice in that state. Note, however, that payment will not be made to a dental laboratory.

[ARC 0314D, IAB 5/27/26, effective 7/1/26]

441—77.6(249A) Podiatrists. All podiatrists licensed to practice in the state of Iowa are eligible to participate in the program. Podiatrists in other states are also eligible if duly licensed to practice in that state.

[ARC 0314D, IAB 5/27/26, effective 7/1/26]

441—77.7(249A) Optometrists. All optometrists licensed to practice in the state of Iowa are eligible to participate in the program. Optometrists in other states are also eligible if duly licensed to practice in that state.

[ARC 0314D, IAB 5/27/26, effective 7/1/26]

441—77.8(249A) Opticians. All opticians in the state of Iowa are eligible to participate in the program. Opticians in other states are also eligible to participate.

NOTE: Opticians in states having licensing requirements for this professional group must be duly licensed in that state.

[ARC 0314D, IAB 5/27/26, effective 7/1/26]

441—77.9(249A) Chiropractors. All chiropractors licensed to practice in the state of Iowa are eligible to participate provided that they have been determined eligible to participate in Title XVIII of the Social Security Act (Medicare) as amended to July 1, 2026, by the Social Security Administration. Chiropractors in other states are also eligible if duly licensed to practice in that state and determined eligible to participate in Title XVIII of the Social Security Act as amended to July 1, 2026.

[ARC 0314D, IAB 5/27/26, effective 7/1/26]

441—77.10(249A) Home health agencies. Home health agencies are eligible to participate provided that they are certified to participate in the Medicare program (Title XVIII of the Social Security Act as amended to July 1, 2026) and, unless otherwise exempted, have submitted a surety bond as required by subrules 77.10(2) through 77.10(4).

77.10(1) Definitions.

“Assets” includes any listing that identifies Medicaid members to whom home health services were furnished by a participating or formerly participating home health agency.

“Rider” means a notice issued by a surety that a change in the bond has occurred or will occur.

“Uncollected overpayment” means a Medicaid overpayment, including accrued interest, for which the home health agency is responsible that has not been recouped by the department within 60 days from the date of notification that an overpayment has been identified.

77.10(2) *Parties to surety bonds.* The surety bond shall name the home health agency as the principal, the department as the obligee and the surety company (and its heirs, executors, administrators, successors and assignees, jointly and severally) as surety. The bond shall be issued by a company holding a current Certificate of Authority issued by the U.S. Department of the Treasury in accordance with 31 U.S.C. Sections 9304 through 9308 and 31 CFR Part 223, both as amended to July 1, 2026, and 31 CFR Parts 224 and 225, both as amended to July 1, 2026. The bond shall list the surety's name, street address or post office box number; city; state; and ZIP code. The company shall not have been determined by the department to be unauthorized in Iowa due to:

a. Failure to furnish timely confirmation of the issuance of and the validity and accuracy of information appearing on a surety bond that a home health agency presents to the department that shows the surety company as surety on the bond.

b. Failure to timely pay the department in full the amount requested, up to the face amount of the bond, upon presentation by the department to the surety company of a request for payment on a surety bond and of sufficient evidence to establish the surety company's liability on the bond.

c. Other good cause.

The department will give public notice of a determination that a surety company is unauthorized in Iowa and the effective date of the determination by publication of a notice in the newspaper of widest circulation in each city in Iowa with a population of 50,000 or more. A list of surety companies determined by the department to be unauthorized in Iowa will be maintained and will be available for public inspection by contacting the department. The determination that a surety company is unauthorized in Iowa has effect only in Iowa and is not a debarment, suspension, or exclusion for the purposes of Federal Executive Order No. 12549.

77.10(3) *Surety company obligations.* The bond shall guarantee payment to the department, up to the face amount of the bond, of the full amount of any uncollected overpayment, including accrued interest, based on payments made to the home health agency during the term of the bond. The bond shall provide that payment may be demanded from the surety after available administrative collection methods for collecting from the home health agency have been exhausted.

77.10(4) *Surety bond requirements.* Surety bonds secured by home health agencies participating in Medicaid shall comply with 42 CFR 484 Subparts A, B, and C as amended to July 1, 2026, and with the Medicare Program Integrity Manual, Chapter 10.2.5.3, as amended to July 1, 2026.

[ARC 0314D, IAB 5/27/26, effective 7/1/26]

441—77.11(249A) Medical equipment and appliances, prosthetic devices and medical supplies. All dealers in medical equipment and appliances, prosthetic devices and medical supplies in Iowa or in other states are eligible to participate in the program.

[ARC 0314D, IAB 5/27/26, effective 7/1/26]

441—77.12(249A) Ambulance service. Providers of ambulance service are eligible to participate provided that they meet the eligibility requirements for participation in the Medicare program (Title XVIII of the Social Security Act as amended to July 1, 2026) and Iowa Code section 147A.8.

[ARC 0314D, IAB 5/27/26, effective 7/1/26]

441—77.13(249A) Behavioral health intervention. A provider of behavioral health intervention is eligible to participate in the medical assistance program when the provider is accredited by one of the following bodies:

1. The Joint Commission (TJC) accreditation, or
2. The Healthcare Facilities Accreditation Program (HFAP), or
3. The Commission on Accreditation of Rehabilitation Facilities (CARF), or
4. The Council on Accreditation (COA), or
5. The Accreditation Association for Ambulatory Health Care (AAAHC), or
6. The Department, pursuant to 441—Chapter 24.

[ARC 0314D, IAB 5/27/26, effective 7/1/26]

441—77.14(249A) Hearing aid dispensers. Hearing aid dispensers are eligible to participate if they are duly licensed by the state of Iowa. Hearing aid dispensers in other states will be eligible to participate if they are duly licensed in that state.

[ARC 0314D, IAB 5/27/26, effective 7/1/26]

441—77.15(249A) Audiologists. Audiologists are eligible to participate in the program when they are duly licensed by the state of Iowa. Audiologists in other states will be eligible to participate when they are duly licensed in that state. In states having no licensure requirement for audiologists, an audiologist shall obtain a license from the state of Iowa.

[ARC 0314D, IAB 5/27/26, effective 7/1/26]

441—77.16(249A) Community mental health centers. Community mental health centers are eligible to participate in the medical assistance program when they are accredited pursuant to 441—Chapter 24.

[ARC 0314D, IAB 5/27/26, effective 7/1/26]

441—77.17(249A) Screening centers. Public or private health agencies are eligible to participate as screening centers when they have the staff and facilities needed to perform all of the elements of screening specified in rule 441—78.18(249A) and meet the department's standards for a child health screening center. The staff members must be employed by or under contract with the screening center. Screening centers shall direct applications to participate to the department.

[ARC 0314D, IAB 5/27/26, effective 7/1/26]

441—77.18(249A) Physical therapists. Physical therapists are eligible to participate when they are licensed, in independent practice, and are eligible to participate in the Medicare program.

[ARC 0314D, IAB 5/27/26, effective 7/1/26]

441—77.19(249A) Orthopedic shoe dealers and repair shops. Establishments eligible to participate in the medical assistance program are retail dealers in orthopedic shoes prescribed by physicians or podiatrists and shoe repair shops specializing in orthopedic work as prescribed by physicians or podiatrists.

[ARC 0314D, IAB 5/27/26, effective 7/1/26]

441—77.20(249A) Rehabilitation agencies. Rehabilitation agencies are eligible to participate provided that they are certified to participate in the Medicare program (Title XVIII of the Social Security Act as amended to July 1, 2026).

[ARC 0314D, IAB 5/27/26, effective 7/1/26]

441—77.21(249A) Independent laboratories. Independent laboratories are eligible to participate provided that they are certified to participate as a laboratory in the Medicare program (Title XVIII of the Social Security Act as amended to July 1, 2026). An independent laboratory is a laboratory that is independent of attending and consulting physicians' offices, hospitals, and critical access hospitals.

[ARC 0314D, IAB 5/27/26, effective 7/1/26]

441—77.22(249A) Rural health clinics. Rural health clinics are eligible to participate provided that they are certified to participate in the Medicare program (Title XVIII of the Social Security Act as amended to July 1, 2026).

[ARC 0314D, IAB 5/27/26, effective 7/1/26]

441—77.23(249A) Psychologists.

77.23(1) All psychologists licensed to practice in the state of Iowa pursuant to Iowa Code chapter 154B are eligible to participate in the medical assistance program. Psychologists in other states are eligible to participate when they are duly licensed to practice in that state and meet the

credentialing requirements of the National Register of Health Service Psychologists as amended to July 1, 2026.

77.23(2) A psychologist provisionally licensed to practice in the state of Iowa pursuant to Iowa Code section 154B.6 is eligible to participate in the medical assistance program when the person:

a. Possesses a doctoral degree in psychology from an institution approved by the board of psychology; and

b. Provides treatment under the supervision of a licensed psychologist pursuant to Iowa Code section 154B.6. Claims for payment for such services must be submitted by the licensed psychologist.

77.23(3) A psychologist provisionally licensed in another state is eligible to participate when the person:

a. Possesses a doctoral degree in psychology from an institution approved by the board of psychology; and

b. Provides treatment under the supervision of a licensed psychologist pursuant to Iowa Code section 154B.6. Claims for payment for such services must be submitted by the licensed psychologist who is duly licensed to practice in that state.

[ARC 0314D, IAB 5/27/26, effective 7/1/26]

441—77.24(249A) Maternal health centers. A maternal health center is eligible to participate in the Medicaid program if the center provides a team of professionals to render prenatal and postpartum care and enhanced perinatal services (see rule 441—78.25(249A) for more information). The prenatal and postpartum care shall be in accordance with the American College of Obstetricians and Gynecologists, Standards for Obstetric Gynecologic Services, as amended to July 1, 2026.

[ARC 0314D, IAB 5/27/26, effective 7/1/26]

441—77.25(249A) Ambulatory surgical centers. Ambulatory surgical centers that are not part of hospitals are eligible to participate in the medical assistance program if the ambulatory surgical centers are certified to participate in the Medicare program (Title XVIII of the Social Security Act as amended to July 1, 2026). Freestanding ambulatory surgical centers providing only dental services are also eligible to participate in the medical assistance program if the dental board has issued a current permit pursuant to 481—Chapter 579 for any dentist to administer deep sedation or general anesthesia at the facility.

[ARC 0314D, IAB 5/27/26, effective 7/1/26]

441—77.26(249A) Federally qualified health centers. Federally qualified health centers are eligible to participate in the Medicaid program when the Centers for Medicare and Medicaid Services has notified the Medicaid program of the federally qualified health centers' eligibility as allowed by Section 6404(b) of Public Law 101–239 as amended to July 1, 2026.

[ARC 0314D, IAB 5/27/26, effective 7/1/26]

441—77.27(249A) Advanced registered nurse practitioners. Advanced registered nurse practitioners are eligible to participate in the Medicaid program if they are duly licensed and registered by the state of Iowa as advanced registered nurse practitioners certified pursuant to 481—Chapter 621.

77.27(1) Advanced registered nurse practitioners in another state shall be eligible to participate if they are duly licensed and registered in that state as advanced registered nurse practitioners with certification in a practice area consistent with 481—Chapter 621.

77.27(2) Advanced registered nurse practitioners who have been certified eligible to participate in Medicare shall be considered as having met these guidelines.

77.27(3) Licensed nurse anesthetists who have graduated from a nurse anesthesia program meeting the standards set forth by a national association of nurse anesthetists within the past 18 months and who are awaiting initial certification by a national association of nurse anesthetists approved by the board of nursing shall be considered as having met these guidelines.

[ARC 0314D, IAB 5/27/26, effective 7/1/26]

441—77.28(249A) Speech-language pathologists. Speech-language pathologists who are enrolled in the Medicare program are eligible to participate in Medicaid. Speech-language pathologists who are not enrolled in the Medicare program are eligible to participate in Medicaid if they are licensed and in independent practice, as an individual or as a group.

77.28(1) Speech-language pathologists in another state are eligible to participate if they are licensed in that state and meet the Medicare criteria for enrollment.

77.28(2) Speech-language pathologists who provide services to Medicaid members who are also Medicare beneficiaries must be enrolled in the Medicare program.

[ARC 0314D, IAB 5/27/26, effective 7/1/26]

441—77.29(249A) Physician associates. All physician associates licensed to practice in the state of Iowa are eligible for participation in the program. Physician associates duly licensed to practice in other states are also eligible for participation.

[ARC 0314D, IAB 5/27/26, effective 7/1/26]

441—77.30(249A) HCBS habilitation services. To be eligible to participate in the Medicaid program as an approved provider of HCBS habilitation services, a provider shall meet the general requirements in subrules 77.30(2) through 77.30(5) and shall meet the requirements in the subrules applicable to the individual services being provided.

77.30(1) Definitions.

“Certified employment specialist” or *“CES”* means a person who has earned a CES certification through a nationally recognized accrediting body.

“Guardian” means a guardian appointed in probate or juvenile court.

“Home- and community-based services” or *“HCBS”* means the types of person-centered care delivered in the home and community.

“Immediate family member” means any of the following:

1. Husband or wife.
2. Natural or adoptive parent, child, or sibling.
3. Stepparent, stepchild, stepbrother, or stepsister.
4. Father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, or sister-in-law.
5. Grandparent or grandchild.
6. Spouse of grandparent or grandchild.

“Individual employment” means employment in the general workforce where the member interacts with the general public to the same degree as nondisabled persons in the same job and for which the member is paid at or above minimum wage but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by persons without disabilities.

“Individual placement and support” or *“IPS”* means the evidence-based practice of supported employment that is guided by IPS practice principles outlined by the IPS Employment Center and as measured by its most recently published 25-item supported employment fidelity scale available online at ipsworks.org as amended to July 1, 2026.

“Intensive residential service homes” or *“intensive residential services”* means intensive, community-based services provided 24 hours per day, 7 days per week, 365 days per year to individuals with a severe and persistent mental illness who have functional impairments and may also have multi-occurring conditions.

“IPS 25-item supported employment fidelity scale” means the fidelity scale published by the IPS Employment Center as amended to July 1, 2026, resulting in scores of exemplary fidelity, good fidelity, fair fidelity, or not supported employment.

“IPS implementation” means the process advocated by the IPS Employment Center as amended to July 1, 2026.

“IPS reviewer” means a person who is qualified to complete fidelity reviews of IPS services and is one of the following:

1. A person who has provided IPS services or has supervised an IPS team in Iowa that has obtained a fidelity score of “good” or better; has completed the IPS Employment Center’s training as amended to July 1, 2026, to become an IPS reviewer; and has shadowed one or more IPS fidelity reviews;

2. An existing IPS reviewer from a state that is a member of the IPS International Learning Collaborative;

3. An IPS reviewer contracted directly from the IPS Employment Center;

4. A CES with a bachelor’s degree who has completed the IPS Employment Center’s training as amended to July 1, 2026, to become an IPS reviewer and has shadowed one or more IPS fidelity reviews.

“*IPS team*” means, at a minimum, an IPS employment specialist, a behavioral health specialist, Iowa Vocational Rehabilitation Services (IVRS) counselor, and a case manager or care coordinator.

“*IPS trainer*” means a person who is qualified to provide training and technical assistance for IPS implementation and is one of the following:

1. A person who has provided IPS services or has supervised an IPS team in Iowa that has obtained a fidelity score of “good” or better and has completed the IPS Employment Center’s training as amended to July 1, 2026, to become an IPS trainer;

2. An existing IPS trainer from a state that is a member of the IPS International Learning Collaborative;

3. An IPS trainer contracted directly from the IPS Employment Center;

4. A CES with a bachelor’s degree who has completed the IPS Employment Center’s training as amended to July 1, 2026, to become an IPS trainer.

“*Managed care organization*” or “*MCO*” means the same as defined in 441—Chapter 73.

“*Member*” means a person who has been determined to be eligible for Medicaid under 441—Chapter 75.

“*Mental health diagnosis*” means a disorder, dysfunction, or dysphoria diagnosed pursuant to the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association as amended to July 1, 2026, excluding neurodevelopmental disorders, substance use disorders, personality disorders, medication-induced movement disorders and other adverse effects of medication, and other conditions that may be a focus of clinical attention as defined in the current version of the DSM published by the American Psychiatric Association as amended to July 1, 2026.

“*Prospective IPS team*” means a group that is forming an IPS team to deliver IPS services but who has not yet completed implementation phase 4a as amended to July 1, 2026.

“*Provider-owned or controlled setting*” means a setting where the HCBS provider owns the property where the member resides, leases the property from a third party, or has a direct or indirect financial relationship with the property owner that impacts either the care provided to or the financial conditions applicable to the member. The unit or dwelling is a specific physical space that can be owned, rented, or occupied under a legally enforceable agreement by the member receiving services, and the member has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord/tenant law of the state, county, city, or other designated entity. For the settings in which landlord/tenant laws do not apply, the state will ensure that a lease, residency agreement or other form of written agreement will be in place for each HCBS member and that the document provides protections that address eviction processes and appeals comparable to those provided under the jurisdiction’s landlord/tenant law.

“*Provisionally approved IPS team*” means a group that has (1) formed a team to deliver IPS services, (2) completed implementation phase 4a as amended to July 1, 2026, and (3) begun to deliver IPS services.

“*Serious emotional disturbance*” means a diagnosable mental, behavioral, or emotional disorder in a child under 18 that significantly impairs the child’s ability to function in family, school, or community settings. This impairment must be substantial and have lasted long enough to meet specific diagnostic criteria outlined in the DSM as amended to July 1, 2026.

“*Severe and persistent mental illness*” or “*SPMI*” means a documented primary mental health disorder diagnosed by a mental health professional that causes symptoms and impairments in basic mental and behavioral processes that produce distress and major functional disability in adult role functioning inclusive of social, personal, family, educational or vocational roles.

77.30(2) *Organization and staff.*

a. The prospective provider shall demonstrate the fiscal capacity to initiate and operate the specified programs on an ongoing basis.

b. The provider shall complete child abuse, dependent adult abuse, and criminal background screenings pursuant to Iowa Code section 249A.29 before employing a person who will provide direct care.

c. A person providing direct care shall be at least 16 years of age.

d. A person providing direct care shall not be an immediate family member of the member.

77.30(3) *Incident management and reporting.* As a condition of participation in the medical assistance program, HCBS habilitation service providers must comply with the requirements of Iowa Code sections 232.69 and 235B.3 regarding the reporting of child abuse and dependent adult abuse and with the incident management and reporting requirements set forth in the HCBS habilitation provider manual as amended to July 1, 2026.

77.30(4) *Restraint, restriction, and behavioral intervention.* The provider shall have in place a system for the review, approval, and implementation of ethical, safe, humane, and efficient behavioral intervention procedures. All members receiving home- and community-based habilitation services shall be afforded the protections imposed by these rules when any restraint, restriction, or behavioral intervention is implemented.

a. The system shall include procedures to inform the member and the member’s legal guardian of the restraint, restriction, and behavioral intervention policy and procedures at the time of service approval and as changes occur.

b. Restraint, restriction, and behavioral intervention shall be used only for reducing or eliminating maladaptive target behaviors that are identified in the member’s restraint, restriction, or behavioral intervention program.

c. Restraint, restriction, and behavioral intervention procedures shall be designed and implemented only for the benefit of the member and shall never be used as punishment, for the convenience of the staff, or as a substitute for a nonaversive program.

d. Restraint, restriction, and behavioral intervention programs shall be time-limited and shall be reviewed at least quarterly.

e. Corporal punishment and verbal or physical abuse are prohibited.

77.30(5) *Residential and nonresidential settings.* All HCBS, whether residential or nonresidential, shall be provided in accordance with 42 CFR 441.301(4) and (5) as amended to July 1, 2026.

77.30(6) *Case management.* A provider is eligible to participate in the HCBS habilitation program as a provider of case management services if accredited as a case management provider pursuant to 441—Chapter 24.

77.30(7) *Day habilitation.*

a. The following providers may provide day habilitation:

(1) An agency that is accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF) to provide services that qualify as day habilitation under 441—subrule 78.27(8).

(2) An agency that is accredited by CARF to provide other services and has begun providing services that qualify as day habilitation under 441—subrule 78.27(8) since the agency’s last accreditation survey. The agency may provide day habilitation services until the current accreditation expires. When the current accreditation expires, the agency must qualify under subparagraph 77.25(7) “a”(1), “a”(4), or “a”(7).

(3) An agency that is not accredited by CARF but has applied to CARF within the last 12 months for accreditation to provide services that qualify as day habilitation under 441—subrule 78.27(8). An

agency that has not received accreditation within 12 months after application to CARF is no longer a qualified provider.

(4) An agency that is accredited by the Council on Quality and Leadership in Supports for People with Disabilities.

(5) An agency that has applied to the Council on Quality and Leadership in Supports for People with Disabilities for accreditation within the last 12 months. An agency that has not received accreditation within 12 months after application to the Council is no longer a qualified provider.

(6) An agency that is accredited under 441—Chapter 24 to provide day treatment or supported community living services.

(7) An agency that is accredited by the International Center for Clubhouse Development.

(8) An agency that is accredited by TJC.

b. Direct support staff providing day habilitation services shall meet the qualifications as outlined in the HCBS Manual as amended to July 1, 2026.

77.30(8) *Home-based habilitation.*

a. The following agencies may provide home-based habilitation services:

(1) An agency that is certified by the department to provide home-based habilitation services.

(2) An agency that is accredited under 441—Chapter 24 to provide supported community living services.

(3) An agency that is accredited by CARF as a community housing or supported living service provider.

(4) An agency that is accredited by the Council on Quality and Leadership (CQL).

(5) An agency that is accredited by the Council on Accreditation of Services for Families and Children.

(6) An agency that is accredited by TJC.

b. Agencies meeting the criteria under subrule 77.30(9) or 77.40(2) that seek certification as an intensive residential service provider shall meet the following criteria at initial application and annually thereafter. A certified intensive residential service provider shall:

(1) Be enrolled as an HCBS 1915(i) home-based habilitation provider in good standing with Iowa Medicaid.

(2) Provide staffing 24 hours per day, 7 days per week, 365 days per year.

(3) Maintain a minimum staffing ratio of one staff to every two residents. Staffing ratios shall be responsive to the needs of the individuals served.

(4) Ensure that all staff members have the qualifications outlined in the HCBS Manual as amended to July 1, 2026.

(5) Ensure that within the first year of employment, staff members complete 48 hours of training in the subject matter outlined in the HCBS Manual as amended to July 1, 2026.

(6) Provide coordination with the individual's clinical mental health and physical health treatment and other services and supports.

(7) Provide clinical oversight by a mental health professional. The mental health professional shall review and consult on all behavioral health services provided to the individual and any other plans developed for the individual.

(8) Have a written cooperative agreement with an outpatient mental health provider and ensure that individuals have timely access to outpatient mental health services.

(9) Be licensed as a substance abuse treatment program pursuant to Iowa Code chapter 125 or have a written cooperative agreement with and timely access to licensed substance abuse treatment services for those individuals with a demonstrated need.

(10) Accept and serve eligible individuals who are court-ordered to intensive residential services.

(11) Provide services to eligible individuals on a no-reject, no-eject basis.

(12) If funded through HCBS and not licensed as a residential care facility, serve no more than five individuals at a site with approval from the department.

(13) Be located in a neighborhood setting to maximize community integration and natural supports.

(14) Demonstrate specialization in serving individuals with a serious and persistent mental illness or multi-occurring conditions and serve individuals with similar conditions in the same site.

c. Direct support staff providing home-based habilitation services shall meet the qualifications outlined in the HCBS Habilitation Manual as amended to July 1, 2026.

d. The department will approve living units designed to serve up to four persons, except as necessary to prevent an overconcentration of living units in a geographic area.

e. The department will approve a living unit designed to serve five persons if both of the following conditions are met:

(1) Approval will not result in an overconcentration of living units in a geographic area; and

(2) The county in which the living unit is located provides to the department verification in writing that approval is needed to address one or more of the following issues:

1. The quantity of services currently available in the county is insufficient to meet the need; or

2. The quantity of affordable rental housing in the county is insufficient to meet the need; or

3. Approval will result in a reduction in the size or quantity of larger congregate settings.

77.30(9) *Prevocational habilitation.*

a. The following providers may provide prevocational services:

(1) An agency that is accredited by CARF as an organizational employment service provider or a community employment service provider.

(2) An agency that is accredited by the Council on Quality and Leadership.

(3) An agency that is accredited by the International Center for Clubhouse Development.

b. Providers responsible for the payroll of members shall have policies that ensure compliance with state and federal labor laws and regulations.

c. Direct support staff providing prevocational services shall meet the following minimum qualifications in addition to other requirements outlined in administrative rule:

(1) A person providing direct support without line-of-sight supervision shall be at least 18 years of age. A person providing direct support with line-of-sight supervision shall be 16 years of age or older.

(2) A person providing direct support shall, within six months of hire, complete at least 9.5 hours of employment service training as offered through DirectCourse or through the Association of Community Rehabilitation Educators (ACRE)-certified training program as amended to July 1, 2026.

(3) Prevocational direct support staff shall complete four hours of continuing education in employment services annually.

77.30(10) *Supported employment habilitation.*

a. The following agencies may provide supported employment services:

(1) An agency that is accredited by CARF as an organizational employment service provider or a community employment service provider.

(2) An agency that is not accredited by CARF but has applied to CARF within the last 12 months for accreditation to provide services that qualify as supported employment under 441—subrule 78.27(10). An agency that has not received accreditation within 12 months after application to CARF is no longer a qualified provider.

(3) An agency that is accredited by CARF to provide other services and began providing services that qualify as supported employment under 441—subrule 78.27(10) since the agency's last accreditation survey. The agency may provide supported employment services until the current accreditation expires. When the current accreditation expires, the agency must qualify under subparagraph 77.30(10)“a”(1), “a”(2), “a”(5), “a”(6), “a”(7) or “a”(8).

(4) An agency that is not accredited by CARF but has applied to CARF within the last 12 months for accreditation to provide services that qualify as supported employment under 441—subrule 78.27(10). An agency that has not received accreditation within 12 months after application to CARF is no longer a qualified provider.

- (5) An agency that is accredited by the COA.
- (6) An agency that is accredited by TJC.
- (7) An agency that is accredited by the Council on Quality and Leadership.
- (8) An agency that has applied to the Council on Quality and Leadership in Supports for People with Disabilities for accreditation within the last 12 months. An agency that has not received accreditation within 12 months after application to the Council on Quality and Leadership in Supports for People with Disabilities is no longer a qualified provider.
- (9) An agency that is accredited by the International Center for Clubhouse Development.
- b. Providers responsible for the payroll of members shall have policies that ensure compliance with state and federal labor laws and regulations.
- c. Direct support staff providing individual or small-group supported employment or long-term job coaching services shall meet the qualifications outlined in the HCBS Habilitation Manual and HCBS Waiver Manual, both as amended to July 1, 2026.
- d. Providers qualified to offer IPS services shall meet the following requirements:
 - (1) Providers shall meet the provider qualifications listed in this subrule.
 - (2) Providers shall be accredited to provide supported employment and have provided supported employment for a minimum of two years.
 - (3) Providers shall demonstrate adequate funding has been secured for the training and technical assistance required for IPS implementation. Adequate funding is defined as at least the amount required for the start-up of one IPS team to complete all phases of IPS implementation. Evidence of such funding shall be made available to the department at the time of enrollment. Evidence may include a written funding agreement or other documentation from the funder.
 - (4) Providers shall receive training and technical assistance throughout IPS implementation from an IPS trainer. Evidence of the IPS team's agreement for such training and technical assistance shall be made available to the department at the time of enrollment.
 - (5) Prospective IPS teams shall complete IPS implementation as defined in subrule 77.30(1).
 - (6) Prospective IPS teams are provisionally approved until the IPS team has obtained at least a "fair" score on a baseline fidelity review completed by IPS reviewers.
 - (7) Provisionally approved IPS teams shall complete IPS implementation phases 1 through 4a as amended to July 1, 2026, within 12 months of enrolling.
 - (8) Upon completion of IPS implementation phase 4a as amended to July 1, 2026, provisionally approved IPS teams shall deliver IPS services according to the IPS outcomes model.
 - (9) Upon completion of IPS implementation phase 7 as amended to July 1, 2026, IPS teams are qualified to deliver IPS services, subject to the following:
 - 1. IPS teams must obtain a baseline fidelity review score of "fair" or better within 14 months of completion of IPS implementation phase 1. The fidelity review must be completed by IPS reviewers. The fidelity reviews shall be provided to the department upon receipt by the IPS team.
 - 2. In the event an IPS team fails to achieve a fidelity score of "fair" or better, the IPS team shall receive technical assistance to address areas recommended for improvement as identified in the fidelity review. If the subsequent fidelity review results in a score of less than "fair" fidelity, the IPS team will be provisionally approved for no more than 12 months or until the fidelity score again reaches "fair" fidelity, whichever date is earlier.
 - 3. IPS teams that do not achieve a "fair" fidelity score within 12 months from being provisionally approved will no longer be qualified to deliver IPS services until they again reach the minimum "fair" fidelity score.

[ARC 0314D, IAB 5/27/26, effective 7/1/26]

441—77.31(249A) Behavioral health services. The following persons are eligible to participate in the Medicaid program as providers of behavioral health services.

77.31(1) *Licensed marital and family therapists (LMFT).* Any person licensed by the board of behavioral health professionals as a marital and family therapist pursuant to 481—Chapter 880 is

eligible to participate. A marital and family therapist in another state is eligible to participate when duly licensed to practice in that state.

77.31(2) *Temporarily licensed marital and family therapists.* Any person who holds a temporary license to practice marital and family therapy pursuant to Iowa Code section 154D.7 is eligible to participate when the temporarily licensed marital and family therapist provides treatment under the supervision of a qualified marital and family therapist as determined by the board of behavioral health professionals by rule. Claims for payment for such services must be submitted by the supervising licensed marital and family therapist.

77.31(3) *Licensed independent-level social workers (LISW).* Any person licensed by the board of social work as an independent-level social worker pursuant to 481—Chapter 880 is eligible to participate. An independent-level social worker in another state is eligible to participate when duly licensed to practice in that state.

77.31(4) *Licensed master-level social workers (LMSW).*

a. A person licensed by the board of social work as a master-level social worker pursuant to 481—Chapter 880 is eligible to participate when the person:

- (1) Holds a master's or doctoral degree as approved by the board of social work; and
- (2) Provides treatment under the supervision of an independent-level social worker licensed pursuant to 481—Chapter 880.

b. A master-level social worker in another state is eligible to participate when the person:

- (1) Is duly licensed to practice in that state; and
- (2) Provides treatment under the supervision of an independent-level social worker duly licensed in that state.

77.31(5) *Licensed mental health providers (LMP).* Any person licensed by the board of behavioral health professionals as a mental health provider pursuant to Iowa Code chapter 154D and 481—Chapter 880 is eligible to participate. A mental health provider in another state is eligible to participate when duly licensed to practice in that state.

77.31(6) *Temporarily licensed mental health counselors.* Any person temporarily licensed by the board of behavioral health professionals as a mental health counselor pursuant to Iowa Code section 154D.7 is eligible to participate when the temporarily licensed mental health counselor provides treatment under the supervision of a qualified mental health counselor as determined by the board of behavioral health professionals by rule. Claims for payment for such services must be submitted by the supervising licensed mental health counselor.

77.31(7) *Certified alcohol and drug counselors.* Any person certified by the nongovernmental Iowa board of certification as an alcohol and drug counselor is eligible to participate.

77.31(8) *Licensed behavior analysts.* Any person licensed as a behavior analyst pursuant to Iowa Code chapter 154D is eligible to participate. A licensed behavior analyst in another state is eligible to participate when duly licensed to practice in that state.

77.31(9) *Licensed assistant behavior analysts.* A person licensed by the board of psychology as an assistant behavior analyst pursuant to Iowa Code chapter 154D is eligible to participate when the licensed assistant behavior analyst:

- a.* Holds current certification as an assistant behavior analyst by a certifying entity; and
- b.* Provides treatment under the supervision of a behavior analyst licensed pursuant to Iowa Code chapter 154D. Claims for payment for such services must be submitted by the supervising licensed behavior analyst.

77.31(10) *Registered behavior technicians.*

- a.* A person is eligible to participate as a registered behavior technician when the person holds:
 - (1) A current certification from the behavior analyst certification board as a registered behavior technician; or
 - (2) A bachelor's degree.

b. A registered behavior technician must provide treatment under the supervision of a behavior analyst or assistant behavior analyst licensed pursuant to Iowa Code chapter 154D. Claims for payment for such services must be submitted by the supervising licensed behavior analyst.

[ARC 0314D, IAB 5/27/26, effective 7/1/26]

441—77.32(249A) Birth centers. Birth centers are eligible to participate in the Medicaid program if they are licensed or receive reimbursement from at least two third-party payors.

[ARC 0314D, IAB 5/27/26, effective 7/1/26]

441—77.33(249A) Area education agencies. An area education agency is eligible to participate in the Medicaid program when it has a plan for providing comprehensive special education programs and services approved by the Iowa department of education. Covered services shall be provided by personnel who are licensed, endorsed, or registered as provided in this rule and shall be within the scope of the applicable license, endorsement, or registration.

77.33(1) Personnel providing audiological or speech-language services shall be licensed by the board of speech pathology and audiology as a speech pathologist or audiologist pursuant to 481—Chapter 740.

77.33(2) Personnel providing physical therapy shall be licensed by the board of physical and occupational therapy as a physical therapist pursuant to 481—Chapter 800.

77.33(3) Personnel providing occupational therapy shall be licensed by the board of physical and occupational therapy as an occupational therapist pursuant to 481—Chapter 804.

77.33(4) Personnel providing psychological evaluations and counseling or psychotherapy services shall be:

a. Endorsed by the board of educational examiners as a school psychologist pursuant to 282—subrule 27.3(2);

b. Licensed by the board of psychology as a psychologist pursuant to 481—Chapter 880;

c. Licensed by the board of social work as a social worker pursuant to 481—Chapter 880;

d. Licensed by the board of medicine as a physician pursuant to 481—Chapters 652 through 654; or

e. Registered by the nursing board as an advanced registered nurse practitioner pursuant to 481—Chapter 621.

77.33(5) Personnel providing nursing services shall be licensed by the nursing board as a registered or licensed practical nurse pursuant to 481—Chapters 617 through 620.

77.33(6) Personnel providing vision services shall be:

a. Licensed by the nursing board as a registered or licensed practical nurse pursuant to 481—Chapters 617 through 620;

b. Licensed by the board of medicine as a physician pursuant to 481—Chapters 652 through 654; or

c. Licensed by the board of optometry as an optometrist pursuant to 481—Chapter 760.

[ARC 0314D, IAB 5/27/26, effective 7/1/26]

441—77.34(249A) Case management provider organizations. Case management provider organizations meeting the criteria in 441—Chapter 24 are eligible to participate.

[ARC 0314D, IAB 5/27/26, effective 7/1/26]

441—77.35(249A) HCBS health and disability waiver service providers. HCBS health and disability waiver services shall be rendered by an agency meeting the standards and qualifications pursuant to the HCBS Waiver Provider Manual as amended to July 1, 2026. The following providers shall be eligible to participate in the Medicaid HCBS health and disability waiver program if they meet the standards in subrule 77.35(18) and the integrated, community-based settings standards in subrule 77.30(5) and also meet the standards set forth below for the service to be provided and the HCBS provider manual as amended to July 1, 2026.

77.35(1) Home maintenance providers. Home maintenance providers shall be agencies that are:

- a. Certified as a home health agency under Medicare, or
- b. Authorized to provide similar services through a contract with the department for local public health services. The agency must provide a current local public health services contract number.

77.35(2) Home health aide providers. Home health aide providers shall be agencies that are certified to participate in the Medicare program.

77.35(3) Adult day care providers. Adult day care providers shall be agencies that are certified by the department of inspections, appeals, and licensing (DIAL) as being in compliance with the standards for adult day services programs in 481—Chapter 70.

77.35(4) Nursing care providers. Nursing care providers shall be agencies that are certified to participate in the Medicare program as home health agencies.

77.35(5) Respite care providers.

- a. The following agencies may provide respite services:
 - (1) Home health agencies that are certified to participate in the Medicare program.
 - (2) Hospitals licensed pursuant to 481—Chapter 51.
 - (3) Nursing facilities, intermediate care facilities for individuals with intellectual disabilities, and hospitals enrolled as providers in the Iowa Medicaid program.
 - (4) Group living foster care facilities for children licensed by the department according to 441—Chapters 112 and 114 through 116 and child care centers licensed according to 441—Chapter 109.
 - (5) Camps certified by the American Camping Association.
 - (6) Home maintenance providers that meet the conditions of participation set forth in subrule 77.35(1).
 - (7) Adult day care providers that meet the conditions of participation set forth in subrule 77.35(3).
 - (8) Residential care facilities for individuals with intellectual disabilities licensed by DIAL.
 - (9) Assisted living programs certified by DIAL.
- b. Respite providers shall meet the following conditions:
 - (1) Providers shall maintain the following information that shall be updated at least annually:
 1. The member's name, birth date, age, and address and the telephone number of each parent, guardian, or primary caregiver.
 2. An emergency medical care release.
 3. Emergency contact telephone numbers, such as the number of the member's physician and the parents, guardian, or primary caregiver.
 4. The member's medical issues, including allergies.
 5. The member's daily schedule that includes the member's preferences in activities or foods or any other special concerns.

(2) Procedures shall be developed for the dispensing, storage, authorization, and recording of all prescription and nonprescription medications administered. Home health agencies must follow Medicare regulations for medication dispensing.

All medications shall be stored in their original containers, with the accompanying physician's or pharmacist's directions and label intact. Medications shall be stored so they are inaccessible to members and the public. Nonprescription medications shall be labeled with the member's name.

In the case of medications that are administered on an ongoing, long-term basis, authorization shall be obtained for a period not to exceed the duration of the prescription.

(3) Policies shall be developed for:

1. Notifying the parent, guardian or primary caregiver of any injuries or illnesses that occur during respite provision. A parent's, guardian's or primary caregiver's signature is required to verify receipt of notification.
2. Requiring the parent, guardian or primary caregiver to notify the respite provider of any injuries or illnesses that occurred prior to respite provision.

3. Documenting activities and times of respite. This documentation shall be made available to the parent, guardian or primary caregiver upon request.

4. Ensuring the safety and privacy of the individual. Policies shall at a minimum address threat of fire, tornado, or flood and bomb threats.

c. A facility providing respite under this subrule shall not exceed the facility's licensed capacity, and services shall be provided in locations consistent with licensure.

d. Respite provided outside the member's home or the facility covered by the licensure, certification, accreditation, or contract must be approved by the parent, guardian or primary caregiver and the interdisciplinary team and must be consistent with the way the location is used by the general public. Respite in these locations shall not exceed 72 continuous hours.

77.35(6) *Counseling providers.* Counseling providers shall be:

a. Agencies that are certified under the community mental health center standards set forth in 441—Chapter 24.

b. Agencies that are licensed as meeting the hospice standards and requirements set forth in 481—Chapter 53 or that are certified to meet the standards under the Medicare program for hospice programs.

c. Agencies that are accredited under the mental health service provider standards set forth in 441—Chapter 24.

77.35(7) *Attendant care providers.* The following providers may provide attendant care service:

a. Agencies authorized to provide similar services through a contract with the department for local public health services. The agency must provide a current local public health services contract number.

b. Home health agencies that are certified to participate in the Medicare program.

c. Community action agencies as designated in Iowa Code section 216A.93.

d. Providers certified under an HCBS waiver for supported community living.

e. Assisted living programs that are certified by DIAL under 481—Chapter 69.

f. Adult day service providers that are certified by DIAL under 481—Chapter 70.

g. Community businesses that are engaged in the provision of attendant care services and that:

(1) Have all necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations, and

(2) Submit verification of current liability and workers' compensation coverage.

77.35(8) *Interim medical monitoring and treatment providers.*

a. The following providers may provide interim medical monitoring and treatment services:

(1) Home health agencies certified to participate in the Medicare program.

(2) Supported community living providers certified according to subrule 77.40(2) or 77.42(12).

b. Staff requirements. Staff members providing interim medical monitoring and treatment services to members shall meet all of the following requirements:

(1) Be at least 18 years of age.

(2) Not be the spouse of the member or a parent or stepparent of the member if the member is aged 17 or under.

(3) Not be a usual caregiver of the member.

(4) Be qualified by training or experience to provide medical intervention or intervention in a medical emergency necessary to carry out the member's plan of care. The training or experience required must be determined by the member's usual caregivers and a licensed medical professional on the member's interdisciplinary team and must be documented in the member's service plan.

77.35(9) *Home and vehicle modification providers.* The following providers may provide home and vehicle modification:

a. Area agencies on aging as designated in 441—Chapter 226.

b. Community action agencies as designated in Iowa Code section 216A.93.

c. Community businesses that have all necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations and that submit verification of current liability and workers' compensation coverage.

77.35(10) *Personal emergency response system providers.* Personal emergency response system providers shall be agencies that meet the following conditions:

a. The agency shall provide an electronic component to transmit a coded signal via digital equipment over telephone lines to a central monitoring station. The central monitoring station must operate receiving equipment and be fully staffed by trained attendants 24 hours per day, seven days per week. The attendants must process emergency calls and ensure the timely notification of appropriate emergency resources to be dispatched to the person in need.

b. The agency, parent agency, institution or corporation shall have the necessary legal authority to operate in conformity with federal, state and local laws and regulations.

c. There shall be a governing authority that is responsible for establishing policy and ensuring effective control of services and finances. The governing authority shall employ or contract for an agency administrator to whom authority and responsibility for overall agency administration are delegated.

d. The agency or institution shall be in compliance with all applicable laws and regulations relating to prohibition of discriminatory practices.

e. There shall be written policies and procedures established to explain how the service operates, agency responsibilities, client responsibilities and cost information.

77.35(11) *Home-delivered meals.* The following providers may provide home-delivered meals:

a. Area agencies on aging as designated in 441—Chapter 226. Home-delivered meals providers subcontracting with area agencies on aging or with letters of approval from the area agencies on aging stating the organization is qualified to provide home-delivered meals services may also provide home-delivered meals services.

b. Community action agencies as designated in Iowa Code section 216A.93.

c. Nursing facilities licensed pursuant to Iowa Code chapter 135C.

d. Restaurants licensed and inspected under Iowa Code chapter 137F.

e. Hospitals enrolled as Medicaid providers.

f. Home health aide providers meeting the standards set forth in subrule 77.35(2).

g. Medical equipment and supply dealers certified to participate in the Medicaid program.

h. Homemaker service providers meeting the standards set forth in subrule 77.35(1).

77.35(12) *Nutritional counseling.* The following providers may provide nutritional counseling by a dietitian licensed under 481—Chapter 921:

a. Hospitals enrolled as Medicaid providers.

b. Community action agencies as designated in Iowa Code section 216A.93.

c. Nursing facilities licensed pursuant to Iowa Code chapter 135C.

d. Home health agencies certified by Medicare.

e. Independent dietitians licensed pursuant to 481—Chapter 921.

77.35(13) *Financial management service.* Members who select the consumer choices option may work with a financial institution that meets the following qualifications:

a. The financial institution shall either:

(1) Be cooperative, nonprofit, member-owned and member-controlled, and federally insured through and chartered by either the National Credit Union Administration (NCUA) or the credit union division of the Iowa department of commerce; or

(2) Be chartered by the Office of the Comptroller of the Currency, a bureau of the U.S. Department of the Treasury, and insured by the Federal Deposit Insurance Corporation (FDIC).

b. The financial institution shall obtain an Internal Revenue Service federal employee identification number dedicated to the financial management service.

c. The financial institution shall enroll as a Medicaid provider.

77.35(14) *Independent support brokerage.* Members who select the consumer choices option shall work with an independent support broker who meets the following qualifications:

- a.* The broker must be at least 18 years of age.
- b.* The broker shall not be the member's guardian, conservator, attorney in fact under a durable power of attorney for health care, power of attorney for financial matters, trustee, or representative payee.
- c.* The broker shall not provide any other paid service to the member.
- d.* The broker shall not work for an individual or entity that is providing services to the member.
- e.* The broker must consent to a criminal background check and child and dependent adult abuse checks. The results shall be provided to the member.
- f.* The broker must complete independent support brokerage training approved by the department.

77.35(15) *Self-directed personal care.* Members who elect the consumer choices option may choose to purchase self-directed personal care services from an individual or business that meets the requirements outlined in the HCBS Manual as amended to July 1, 2026.

77.35(16) *Individual-directed goods and services.* Members who elect the consumer choices option may choose to purchase individual-directed goods and services from an individual or business that meets the requirements outlined in the HCBS Manual as amended to July 1, 2026.

77.35(17) *Self-directed community supports and employment.* Members who elect the consumer choices option may choose to purchase self-directed community supports and employment from an individual or business that meets the requirements outlined in the HCBS Manual as amended to July 1, 2026.

[ARC 0314D, IAB 5/27/26, effective 7/1/26]

441—77.36(249A) Occupational therapists. Occupational therapists are eligible to participate if they are licensed and in private practice independent of the administrative and professional control of an employer, such as a physician, institution, or rehabilitation agency. Licensed occupational therapists in an independent group practice are eligible to enroll.

77.36(1) Occupational therapists in other states are eligible to participate if they are licensed in that state and meet the Medicare criteria for enrollment.

77.36(2) Occupational therapists who provide services to Medicaid members who are also Medicare beneficiaries must be enrolled in the Medicare program.

[ARC 0314D, IAB 5/27/26, effective 7/1/26]

441—77.37(249A) Hospice providers. Hospice providers that are licensed and meet the hospice standards and requirements set forth in 481—Chapter 53 or that are certified to meet the standards under the Medicare program for hospice programs are eligible to participate in the Medicaid program.

[ARC 0314D, IAB 5/27/26, effective 7/1/26]

441—77.38(249A) HCBS elderly waiver service providers. HCBS elderly waiver services shall be rendered by a person who meets the training and qualification specified in the HCBS Waiver Provider Manual as amended to July 1, 2026. The following providers are eligible to participate in the Medicaid HCBS elderly waiver program if they meet the standards in subrule 77.38(22) and the integrated, community-based settings standards in subrule 77.30(5) and also meet the standards set forth below for the service to be provided.

77.38(1) *Adult day care providers.* Adult day care providers meeting the criteria outlined in subrule 77.35(3) are eligible to participate.

77.38(2) *Emergency response system providers.* Emergency response system providers must meet the following standards:

- a.* The agency shall provide an electronic component to transmit a coded signal via digital equipment over telephone lines to a central monitoring station. The central monitoring station must operate receiving equipment and be fully staffed by trained attendants 24 hours per day, seven

days per week. The attendants must process emergency calls and ensure the timely notification of appropriate emergency resources to be dispatched to the person in need.

b. The agency, parent agency, institution or corporation shall have the necessary legal authority to operate in conformity with federal, state and local laws and regulations.

c. There shall be a governing authority that is responsible for establishing policy and ensuring effective control of services and finances. The governing authority shall employ or contract for an agency administrator to whom authority and responsibility for overall agency administration are delegated.

d. The agency or institution shall be in compliance with all applicable laws and regulations relating to prohibition of discriminatory practices.

e. There shall be written policies and procedures established to explain how the service operates, agency responsibilities, client responsibilities and cost information.

77.38(3) *Home health aide providers.* Home health aide providers meeting the criteria outlined in subrule 77.35(2) are eligible to participate.

77.38(4) *Homemaker service providers.* Homemaker service providers meeting the criteria in subrule 77.35(1) are eligible to participate.

77.38(5) *Nursing care.* Nursing care providers meeting the criteria in subrule 77.35(4) are eligible to participate.

77.38(6) *Respite care.* Respite care providers meeting the criteria in subrule 77.35(5) are eligible to participate.

77.38(7) *Home-delivered meals providers.* Home-delivered meals providers meeting the criteria outlined in subrule 77.35(11) are eligible to participate.

77.38(8) *Home and vehicle modification providers.* Home and vehicle modification providers meeting the criteria outlined in subrule 77.35(9) are eligible to participate.

77.38(9) *Mental health outreach providers.* Community mental health centers or other accredited behavioral health providers meeting the criteria outlined in rule 441—77.31(249A) may provide mental health outreach services.

77.38(10) *Transportation service providers.* The following providers may provide transportation services:

a. Area agencies on aging as designated in 441—Chapter 226. Transportation providers subcontracting with area agencies on aging or with letters of approval from the area agencies on aging stating the organization is qualified to provide transportation services may also provide transportation services.

b. Community action agencies as designated in Iowa Code section 216A.93.

c. Regional transit agencies as recognized by the department of transportation.

d. Supported community living providers certified pursuant to subrule 77.40(2) or 77.42(12).

e. Nursing facilities licensed pursuant to Iowa Code chapter 135C.

f. Transportation providers contracting with the nonemergency medical transportation broker.

77.38(11) *Nutritional counseling.* Providers meeting the criteria outlined in subrule 77.35(12) may provide nutritional counseling.

77.38(12) *Assistive device providers.* The following providers may provide assistive devices:

a. Medicaid-enrolled medical equipment and supply dealers.

b. Area agencies on aging as designated according to 441—Chapter 226.

c. Providers that were enrolled as assistive device providers as of June 30, 2010, based on a contract with or letter of approval from an area agency on aging.

d. Community businesses that are engaged in the provision of assistive devices and that:

(1) Have all necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations, and

(2) Submit verification of current liability and workers' compensation coverage.

77.38(13) *Companion services.* Senior companion programs designated by the Corporation for National and Community Service may provide companion services.

77.38(14) *Attendant care providers.* Attendant care providers meeting the criteria outlined in subrule 77.35(7) are eligible to participate.

77.38(15) *Financial management service.* Members who select the consumer choices option may work with a financial institution that meets the qualifications in subrule 77.35(13).

77.38(16) *Independent support brokerage.* Members who select the consumer choices option shall work with an independent support broker who meets the criteria outlined in subrule 77.35(14).

77.38(17) *Self-directed personal care.* Members who elect the consumer choices option may choose to purchase self-directed personal care services from an individual or business that meets the requirements outlined in subrule 77.35(15).

77.38(18) *Individual-directed goods and services.* Members who elect the consumer choices option may choose to purchase individual-directed goods and services from an individual or business that meets the requirements outlined in subrule 77.35(16).

77.38(19) *Self-directed community supports and employment.* Members who elect the consumer choices option may choose to purchase self-directed community supports and employment from an individual or business that meets the requirements outlined in subrule 77.35(17).

77.38(20) *Case management providers.* A case management provider organization is eligible to participate in the Medicaid HCBS elderly waiver program if the organization meets the standards outlined in 441—Chapter 90.

77.38(21) *Incident management and reporting.* As a condition of participation in the medical assistance program, HCBS elderly waiver service providers must comply with the requirements of Iowa Code sections 232.69 and 235B.3 regarding the reporting of child abuse and dependent adult abuse and with the incident management and reporting requirements set forth in the HCBS Waiver Provider Manual as amended to July 1, 2026, except for providers of assistive devices, chore service, goods and services purchased under the consumer choices option, home and vehicle modification, home-delivered meals, personal emergency response, or transportation.

77.38(22) *Assisted living on-call service.* Assisted living on-call service providers shall be assisted living programs that are certified by DIAL under 481—Chapter 69.

[ARC 0314D, IAB 5/27/26, effective 7/1/26]

441—77.39(249A) HCBS AIDS/HIV waiver service providers. HCBS AIDS/HIV waiver services shall be rendered by a person who meets the training and qualification specified in the HCBS Waiver Provider Manual as amended to July 1, 2026. The following providers shall be eligible to participate in the Medicaid HCBS AIDS/HIV waiver program.

77.39(1) *Counseling providers.* Counseling providers that meet the criteria outlined in subrule 77.35(6).

77.39(2) *Home health aide providers.* Home health aide providers that meet the requirements outlined in subrule 77.35(2).

77.39(3) *Home maintenance providers.* Home maintenance providers that meet the requirements outlined in subrule 77.35(1).

77.39(4) *Nursing care providers.* Nursing care providers that meet the requirements outlined in subrule 77.35(4).

77.39(5) *Respite care providers.* Respite care providers that meet the criteria outlined in subrule 77.35(5).

77.39(6) *Home-delivered meal providers.* Home-delivered meal providers that meet the criteria outlined in subrule 77.35(11).

77.39(7) *Adult day care providers.* Adult day care providers that meet the criteria outlined in subrule 77.35(3).

77.39(8) *Attendant care providers.* Attendant care providers that meet the criteria outlined in subrule 77.35(7).

77.39(9) *Financial management service.* Members who select the consumer choices option may work with a financial institution that meets the qualifications outlined in subrule 77.35(13).

77.39(10) *Independent support brokerage.* Members who select the consumer choices option shall work with an independent support broker who meets the qualifications outlined in subrule 77.35(14).

77.39(11) *Self-directed personal care.* Members who select the consumer choices option may choose to purchase self-directed personal care services from an individual or business that meets the requirements outlined in subrule 77.35(15).

77.39(12) *Individual-directed goods and services.* Members who select the consumer choices option may choose to purchase individual-directed goods and services from an individual or business that meets the requirements outlined in subrule 77.35(16).

77.39(13) *Self-directed community supports and employment.* Members who select the consumer choices option may choose to purchase self-directed community supports and employment from an individual or business that meets the requirements outlined in subrule 77.35(17).

77.39(14) *Incident management and reporting.* As a condition of participation in the medical assistance program, HCBS AIDS/HIV waiver service providers, except for providers of goods and services purchased under the consumer choices option or home-delivered meals, must comply with the requirements of Iowa Code sections 232.69 and 235B.3 regarding the reporting of child abuse and dependent adult abuse and with the incident management and reporting requirements set forth in the HCBS Waiver Provider Manual as amended to July 1, 2026.

[ARC 0314D, IAB 5/27/26, effective 7/1/26]

441—77.40(249A) HCBS intellectual disability waiver service providers. HCBS intellectual disability waiver services shall be rendered by providers meeting the standards and qualifications outlined in the HCBS Waiver Provider Manual as amended to July 1, 2026.

77.40(1) *Review of providers.* Reviews of compliance with standards as indicated in this chapter and the requirements set forth in the HCBS Waiver Provider Manual as amended to July 1, 2026, will be conducted by designated department team members.

77.40(2) *Supported community living (SCL) providers.*

a. The department will contract only with public or private agencies to provide the SCL service. The department does not recognize individuals as service providers under the SCL program.

b. Providers of services meeting the definition of foster care shall also be licensed according to applicable rules in 441—Chapters 108, 112, 114, 115, and 116.

c. Providers of SCL may employ or contract with individuals meeting the definition of foster family homes to provide supported community living services. These individuals shall be licensed according to applicable rules in 441—Chapters 112 and 113.

d. Agencies meeting the criteria under subrule 77.40(2) that seek designation as an intensive residential service provider shall meet the criteria pursuant to paragraph 77.30(8)“b” at initial application and annually thereafter.

e. All SCL providers shall meet the following requirements:

(1) The provider shall demonstrate the outcomes and processes in this rule for each of the members being served.

(2) Reserved.

77.40(3) *Respite care providers.* Respite care providers meeting the criteria in subrule 77.35(5) are eligible to participate.

77.40(4) *Supported employment providers.* Supported employment providers meeting the criteria outlined in subrule 77.25(9) are eligible to participate.

77.40(5) *Home and vehicle modification providers.* Home and vehicle modification providers meeting the criteria outlined in subrule 77.35(9) are eligible to participate.

77.40(6) *Personal emergency response system providers.* Personal emergency response system providers meeting the criteria outlined in subrule 77.35(10) are eligible to participate.

77.40(7) *Nursing providers.* Nursing providers shall be agencies that are certified to participate in the Medicare program as home health agencies.

77.40(8) *Home health aide providers.* Home health aide providers meeting the criteria outlined in subrule 77.35(2) are eligible to participate.

77.40(9) *Attendant care providers.* Attendant care providers meeting the criteria outlined in subrule 77.35(7) are eligible to participate.

77.40(10) *Interim medical monitoring and treatment providers.* Interim medical monitoring and treatment providers meeting the criteria outlined in subrule 77.35(8) are eligible to participate.

77.40(11) *Residential-based supported community living service providers.*

a. The department will only enroll public or private agencies to provide residential-based supported community living services.

b. Subject to the requirements of this rule, the following agencies may provide residential-based supported community living services:

(1) Agencies licensed as group living foster care facilities under 441—Chapter 114.

(2) Agencies licensed as residential facilities for children with an intellectual disability or brain injury under 441—Chapter 116.

(3) Agencies certified by the department to provide residential-based supported community living services. Residential-based supported community living service providers shall meet the following conditions:

1. The agency must provide orientation training on the agency's purpose, policies, and procedures within one month of hire or contracting for all employed and contracted treatment staff and must provide 24 hours of training during the first year of employment or contracting. The agency must also provide at least 12 hours of training per year after the first year of employment for all employed and contracted treatment staff. Annual training shall include, at a minimum, training on children's intellectual disabilities and developmental disabilities services and children's mental health issues. Identification and reporting of child abuse shall be covered in training at least every three years in accordance with Iowa Code section 232.69.

2. The agency must have standards for the rights and dignity of children that are age-appropriate. These standards shall include the following:

- Children, their families, and their legal representatives decide what personal information is shared and with whom.

- Children are a part of family and community life and perform varied social roles.
- Children have family connections, a social network, and varied relationships.
- Children develop and accomplish personal goals.
- Children are valued.
- Children live in positive environments.
- Children exercise their rights and responsibilities.
- Children make informed choices about how they spend their free time.
- Children choose their daily routine.

3. The agency must use methods of self-evaluation by which:

- Past performance is reviewed.
- Current functioning is evaluated.
- Plans are made for the future based on the review and evaluation.

4. The agency must have a governing body that receives and uses input from a wide range of local community interests and member representatives and provides oversight that ensures the provision of high-quality supports and services to children.

5. Children, their parents, and their legal representatives must have the right to appeal the service provider's application of policies or procedures or any staff person's action that affects the member. The service provider shall distribute the policies for member appeals and procedures to children, their parents, and their legal representatives.

c. As a condition of participation, all providers of residential-based supported community living services must have the following on file:

(1) Current accreditations, evaluations, inspections, and reviews by applicable regulatory and licensing agencies and associations.

(2) Documentation of the fiscal capacity of the provider to initiate and operate the specified programs on an ongoing basis.

(3) The provider's written agreement to work cooperatively with the department.

d. As a condition of participation, all providers of residential-based supported community living services must develop, review, and revise service plans for each child as follows:

(1) The service plan shall be developed in collaboration with the social worker or case manager, child, family, and, if applicable, the foster parents unless a treatment rationale for the lack of involvement of one of these parties is documented in the plan. The service provider shall document the dates and content of the collaboration on the service plan. The service provider shall provide a copy of the service plan to the family and the case manager unless otherwise ordered by a court of competent jurisdiction.

(2) Initial service plans shall be developed after services have been authorized and within 30 calendar days of initiating services.

(3) The service plan shall identify the following:

1. Strengths and needs of the child.
2. Goals to be achieved to meet the needs of the child.
3. Objectives for each goal that are specific, measurable, and time-limited and include indicators of progress toward each goal.

4. Specific service activities to be provided to achieve the objectives.

5. The persons responsible for providing the services. When daily living and social skills development is provided in a group care setting, designation may be by job title.

6. Date of service initiation and date of individual service plan development.

7. Service goals describing how the child will be reunited with the child's family and community.

(4) Individuals qualified to provide all services identified in the service plan shall review the services identified in the service plan to ensure that the services are necessary, appropriate, and consistent with the identified needs of the child as listed on the interRAI assessment tool as amended to July 1, 2026.

(5) The service worker or case manager shall review all service plans to determine progress toward goals and objectives 90 calendar days from the initiation of services and every 90 calendar days thereafter for the duration of the services.

At a minimum, the provider shall submit written reports to the service worker or case manager at six-month intervals and when changes to the service plan are needed.

(6) The individual service plan shall be revised when any of the following occur:

1. Service goals or objectives have been achieved.
2. Progress toward goals and objectives is not being made.
3. Changes have occurred in the identified service needs of the child as listed on the interRAI assessment tool as amended to July 1, 2026.

4. The service plan is not consistent with the identified service needs of the child, as listed in the service plan.

(7) The service plan shall be signed and dated by qualified staff of each reviewing provider after each review and revision.

(8) Any revisions of the service plan shall be made in collaboration with the child, family, case manager, and, if applicable, the foster parents and shall reflect the needs of the child. The service provider shall provide a copy of the revised service plan to the family and case manager unless otherwise ordered by a court of competent jurisdiction.

e. The residential-based supported community living service provider shall also furnish residential-based living units for all recipients of the residential-based supported community living services. Except as provided herein, living units provided may be of no more than four beds. Service

providers who receive approval from the department may provide living units of up to eight beds. The department shall approve five- to eight-bed living units only if all of the following conditions are met:

(1) There is a need for the service to be provided in a five- to eight-person living unit instead of a smaller living unit, considering the location of the programs in an area.

(2) The provider supplies the department with a written plan acceptable to the department that addresses how the provider will reduce its living units to four-bed units within a two-year period of time. This written plan shall include the following:

1. How the transition will occur.
2. What physical change will need to take place in the living units.
3. How children and their families will be involved in the transitioning process.
4. How this transition will affect children's social and educational environment.
- f. Certification process and review of service providers.

(1) The certification process for providers of residential-based supported community living services shall be pursuant to subrule 77.42(7).

(2) The initial certification of residential-based supported community living services shall be pursuant to subrule 77.42(8).

(3) Period and conditions of certification.

1. Initial certification. Providers eligible for initial certification by the department will be issued an initial certification for 270 calendar days, effective on the date identified on the certificate of approval, based on documentation provided.

2. Recertification. After the initial certification, annual recertification will be based on an on-site review and will be contingent upon demonstration of compliance with certification requirements.

The department will hold an exit conference with the provider to share preliminary findings of the recertification review. The department will write and send to the provider a review report within 30 calendar days unless the parties mutually agree to extend that time frame.

Recertification will be effective on the date identified on the certificate of approval and will terminate one year from the month of issuance.

Corrective actions may be required in connection with recertification and may be monitored through the assignment of follow-up monitoring by written report, a plan of corrective actions and improvements, an on-site review, or the provision of technical assistance.

3. Probational certification. Probational certification for 270 calendar days may be issued to a provider who cannot demonstrate compliance with all certification requirements on recertification review to give the provider time to establish and implement corrective actions and improvement activities.

- During the probational certification period, the department may require monitoring of the implementation of the corrective actions through on-site visits, written reports, or technical assistance.

- Probational certification shall not be renewed or extended and shall require a full on-site follow-up review to be completed. The provider must demonstrate compliance with all certification requirements at the time of the follow-up review in order to maintain certification.

4. Immediate jeopardy. If, during the course of any review, a department review team member encounters a situation that places a member in immediate jeopardy, the department review team member will immediately notify the provider and other department review team members. "Immediate jeopardy" refers to circumstances where the life, health, or safety of a member will be severely jeopardized if the circumstances are not immediately corrected. The provider shall correct the situation within 24 to 48 hours. If the situation is not corrected within the prescribed time frame, the provider will not be certified. The department will immediately discontinue funding for that provider's service. If this action is appealed and the member or legal guardian wants to maintain the provider's services, funding can be reinstated. At that time, the provider shall take appropriate action to ensure the life, health, and safety of the members deemed to be at risk.

5. Abuse reporting. As a mandatory reporter, each department review team member will follow appropriate procedure in all cases where a condition reportable to child and adult protective services is observed.

6. Extensions. The department will establish the length of extensions on a case-by-case basis. The department may grant an extension to the period of certification for the following reasons:

- A delay in the department's approval decision exists that is beyond the control of the provider or department.
- A request for an extension is received from a provider to permit the provider to prepare and obtain department approval of corrective actions.

7. Revocation. The department may revoke the provider's approval at any time for any of the following reasons:

- The findings of a site visit indicate that the provider has failed to implement the corrective actions submitted pursuant to subrule 70.40(1) and numbered paragraph 77.40(11) "f"(3) "4."
- The provider has failed to provide information requested pursuant to subrule 70.40(1) and numbered paragraph 77.40(11) "f"(3) "4."
- The provider refuses to allow the department to conduct a site visit pursuant to subrule 77.40(1) and subparagraph 77.40(11) "f"(3).
- There are instances of noncompliance with the standards that were not identified from information submitted on the application.

8. Notice of intent to withdraw. An approved provider shall immediately notify the department and other interested parties of a decision to withdraw as a provider of residential-based supported community living services.

9. Technical assistance. Following certification, any provider may request technical assistance from the department regarding compliance with program requirements. The department may require that technical assistance be provided to a provider to assist in the implementation of any corrective action plan.

10. Appeals. The provider can appeal any adverse action under 441—Chapter 2506.

(4) Providers of residential-based supported community living services will be subject to reviews of compliance with program requirements.

77.40(12) *Transportation service providers.* Transportation service providers meeting the criteria outlined in subrule 77.38(10) are eligible to participate.

77.40(13) *Adult day care providers.* Adult day care providers meeting the criteria outlined in subrule 77.35(3) are eligible to participate.

77.40(14) *Prevocational service providers.* Prevocational service providers meeting the criteria outlined in subrule 77.30(9) are eligible to participate.

77.40(15) *Day habilitation providers.* Day habilitation services may be provided by agencies meeting the qualifications outlined in subrule 77.30(7).

77.40(16) *Financial management service.* Members who select the consumer choices option may work with a financial institution that meets the qualifications outlined in subrule 77.35(13).

77.40(17) *Independent support brokerage.* Members who select the consumer choices option shall work with an independent support broker who meets the qualifications outlined in subrule 77.35(14).

77.40(18) *Self-directed personal care.* Members who select the consumer choices option may choose to purchase self-directed personal care services from an individual or business that meets the requirements outlined in subrule 77.35(15).

77.40(19) *Individual-directed goods and services.* Members who select the consumer choices option may choose to purchase individual-directed goods and services from an individual or business that meets the requirements outlined in subrule 77.35(16).

77.40(20) *Self-directed community supports and employment.* Members who select the consumer choices option may choose to purchase self-directed community supports and employment from an individual or business that meets the requirements outlined in subrule 77.35(17).

[ARC 0314D, IAB 5/27/26, effective 7/1/26]

441—77.41(249A) Assertive community treatment. Services in the assertive community treatment (ACT) program shall be rendered by a multidisciplinary team composed of practitioners from the disciplines described in this rule. The team shall be under the clinical supervision of a psychiatrist. The program shall designate an individual team member who shall be responsible for administration of the program, including authority to sign documents and receive payment on behalf of the program.

77.41(1) Minimum composition. At a minimum, the team shall consist of a nurse, a mental health service provider, and a substance abuse treatment professional.

77.41(2) Psychiatrists. A psychiatrist on the team shall be a physician (MD or DO) who:

- a. Is licensed under 481—Chapter 653;
- b. Is certified as a psychiatrist by the American Board of Medical Specialties' Board of Psychiatry and Neurology or by the American Osteopathic Board of Neurology and Psychiatry; and
- c. Has experience treating serious and persistent mental illness.

77.41(3) Registered nurses. A nurse on the team shall:

- a. Be licensed as a registered nurse under 481—Chapter 617, and
- b. Have experience treating persons with serious and persistent mental illness.

77.41(4) Behavioral health service providers. A mental health service provider on the team shall be:

- a. A mental health counselor or marital and family therapist who:
 - (1) Is licensed under 481—Chapter 880, and
 - (2) Has experience treating persons with serious and persistent mental illness; or
- b. A social worker who:
 - (1) Is licensed as a master-level or independent-level social worker under 481—Chapter 880, and
 - (2) Has experience treating persons with serious and persistent mental illness.

77.41(5) Psychologists. A psychologist on the team shall:

- a. Be licensed under 481—Chapter 880, and
- b. Have experience treating persons with serious and persistent mental illness.

77.41(6) Substance abuse treatment professionals. A substance abuse treatment professional on the team shall:

- a. Be an appropriately credentialed counselor pursuant to 641—paragraph 155.21(8)“b,” and
- b. Have at least three years of experience treating substance abuse.

77.41(7) Peer specialists. A peer specialist on the team shall be a person with serious and persistent mental illness who has met all requirements of a nationally standardized peer support training program, including at least 30 hours of training and satisfactory completion of an examination.

77.41(8) Community support specialists. A community support specialist on the team shall be a person who:

- a. Has a bachelor's degree (BA or BS) in a human services field (sociology, social work, counseling, psychology, or human services), and
- b. Has experience supporting persons with serious and persistent mental illness.

77.41(9) Case managers. A case manager on the team shall be a person who:

- a. Has a bachelor's degree (BA or BS) in a human services field (sociology, social work, counseling, psychology, or human services),
- b. Has experience managing care for persons with serious and persistent mental illness, and
- c. Meets the qualifications of “qualified case managers and supervisors” in rule 441—24.1(225A).

77.41(10) Advanced registered nurse practitioners. An advanced registered nurse practitioner on the team shall:

- a. Be licensed under 481—Chapter 621,
- b. Have a mental health certification, and

c. Have experience treating serious and persistent mental illness.

77.41(11) Physician associates. A physician associate on the team shall:

a. Be licensed under 481—Chapter 780,

b. Have experience treating persons with serious and persistent mental illness, and

c. Practice under the supervision of a psychiatrist.

[ARC 0314D, IAB 5/27/26, effective 7/1/26]

441—77.42(249A) HCBS brain injury (BI) waiver service providers. HCBS BI waiver service providers shall meet the standards and qualifications outlined in the HCBS Waiver Provider Manual as amended to July 1, 2026. Providers initially enrolling to deliver BI waiver services and each of their staff members involved in direct member service must have completed the department's brain injury training modules within 60 days from the beginning date of service provision, with the exception of staff members who are certified through the Academy of Certified Brain Injury Specialists (ACBIS) as a certified brain injury specialist (CBIS) or certified brain injury specialist trainer (CBIST), providers of home and vehicle modification, specialized medical equipment, transportation, personal emergency response, financial management, independent support brokerage, self-directed personal care, individual-directed goods and services, and self-directed community supports and employment. Services shall be rendered by a person who is at least 16 years old (except as otherwise provided in this rule) and is not the spouse of the member served or the parent or stepparent of a member aged 17 or under. People who are 16 or 17 years old must be employed and supervised by an enrolled HCBS provider unless they are employed to provide self-directed personal care services through the consumer choices option. A person hired for self-directed personal care services need not be supervised by an enrolled HCBS provider. A person hired through the consumer choices option for independent support brokerage, self-directed personal care, individual-directed goods and services, or self-directed community support and employment is not required to enroll as a Medicaid provider and is not subject to review under subrule 77.42(10). Attendant care and interim medical monitoring and treatment providers must be at least 18 years of age.

In addition, behavioral programming, supported community living, and supported employment providers shall meet the outcome-based standards set forth below in subrule 77.42(1) and be evaluated according to subrules 77.42(7) through 77.42(9) and meet the requirements of subrules 77.42(2) through 77.42(6). Respite providers shall also meet the standards outlined in subrule 77.42(1).

The integrated, community-based settings standards in subrule 77.30(5) apply to all HCBS BI waiver service providers.

77.42(1) Outcome-based standards. The provider shall have organizational and rights and dignity outcome-based standards pursuant to the HCBS Waiver Provider Manual as amended to July 1, 2026.

77.42(2) The right to appeal. Members and their legal representatives have the right to appeal the provider's application of policies or procedures or any staff or contractual person's action that affects the member. The provider shall distribute the policies for member appeals and procedures to members.

77.42(3) Storage and provision of medication. If the provider stores, handles, prescribes, dispenses or administers a prescription or an over-the-counter medication, the provider shall develop procedures for the storage, handling, prescribing, dispensing or administration of medication. For controlled substances, procedures shall be in accordance with rule 481—63.16(135C).

77.42(4) Research. If the provider conducts research involving members, the provider shall have written policies and procedures addressing the research. These policies and procedures shall ensure that members' rights are protected.

77.42(5) Incident management and reporting. As a condition of participation in the medical assistance program, HCBS BI waiver service providers, except for providers of goods and services purchased under the consumer choices option or providers of home and vehicle modification, personal emergency response, and transportation, must comply with the requirements of Iowa Code sections

232.69 and 235B.3 regarding the reporting of child abuse and dependent adult abuse and with the incident management and reporting requirements set forth in the HCBS Waiver Provider Manual as amended to July 1, 2026.

77.42(6) *Intake, admission, service coordination, discharge, and referral.*

a. The provider shall have written policies and procedures according to state and federal laws for intake, admission, service coordination, discharge and referral.

b. The provider shall ensure the rights of persons applying for services.

77.42(7) *Certification process.* The department will conduct reviews of compliance with standards for initial certification and recertification. Certification carries no assurance that the approved provider will receive funding.

The department may request any information from the prospective service provider that the department considers pertinent to arriving at a certification decision.

77.42(8) *Initial certification.* The department will review the application and accompanying information to see if the provider has the necessary framework to provide services in accordance with all applicable requirements and standards.

a. The department will make a determination regarding initial certification within 60 days of receipt of the application and notify the provider in writing of the decision unless extended by mutual consent of the parties involved.

b. The department's decision on the provider's initial certification will be based on all relevant information, including:

(1) The application for status as an approved provider according to requirements of rules.

(2) A determination of the financial position of the prospective provider in relation to its ability to meet the stated need.

c. Providers applying for initial certification will be offered technical assistance.

77.42(9) *Period of certification.* Provider certification will become effective on the date identified on the certificate of approval and will terminate in 270 calendar days, one year, or three calendar years from the month of issue. The renewal of certification will be contingent upon demonstration of continued compliance with certification requirements.

a. Initial certification. Providers eligible for initial certification by the department will be issued an initial certification for 270 calendar days based on documentation provided.

b. Recertification. After the initial certification, the level of certification will be based on an on-site review unless the provider has been accredited for similar services by TJC, CARE, the Council on Quality and Leadership (the Council), or COA. The on-site reviews for supported community living and supported employment use interviews with members and significant people in the member's life to determine whether or not the individual value-based outcomes set forth in the HCBS Waiver Provider Manual as amended to July 1, 2026, and corresponding processes are present for the member. Respite services are required to meet certain outcome standards and participate in satisfaction surveys.

(1) Once the outcomes and processes have been determined for all the members in the sample, a department review team then determines which of the outcomes and processes are present for the provider. A specific outcome is present for the provider when the specific outcome is determined to be present for 75 percent or more of the members interviewed. A specific process is present for the provider when the process is determined to be present for 75 percent or more of the members interviewed. Since the processes are in the control of the provider and the outcomes are more in the control of the member, length of certification will be based more heavily on whether or not the processes are in place to help members obtain desired outcomes.

(2) An exit conference will be held with the organization to share preliminary findings of the certification review. The department will write and send a review report to the provider within 30 calendar days unless the parties mutually agree to extend that time frame.

(3) Provider certification will become effective on the date identified on the Certificate of Approval and will terminate in 270 calendar days, one year, or three calendar years from the month

of issue. The renewal of certification will be contingent upon demonstration of continued compliance with certification requirements.

c. The department may issue four categories of recertification:

(1) Three-year certification with excellence. An organization is eligible for certification with excellence if the number of processes present is 18 or higher and the number of outcomes and corresponding processes present together is 12 or higher. Both criteria need to be met to receive three-year certification with excellence. Corrective actions may be required and may be monitored through the assignment of follow-up monitoring either by written report, a plan of corrective actions and improvements, an on-site review, or the provision of technical assistance.

(2) Three-year certification with follow-up monitoring. An organization is eligible for this type of certification if the number of processes present is 17 or higher and the number of outcomes and corresponding processes present together is 11 or higher. Both criteria need to be met to receive three-year certification. Corrective actions are required and may be monitored through the assignment of follow-up monitoring either by written report, a plan of corrective actions and improvements, an on-site review, or the provision of technical assistance.

(3) One-year certification. An organization is eligible for this type of certification when the number of processes present is 14 or higher and the number of outcomes and processes present together is 9 or higher. Both criteria need to be met to receive one-year certification. One-year certification may also be given in lieu of longer certification when previously required corrective actions have not been implemented or completed. Corrective actions are required and may be monitored through the assignment of follow-up monitoring either by written report, a plan of corrective actions and improvements, an on-site review, or the provision of technical assistance.

(4) Probational certification. A probational certification may be issued to those providers who cannot meet requirements for a one-year certification. This time period will be granted to the provider to establish and implement corrective actions and improvement activities. During this time period, the department may require monitoring of the implementation of the corrective actions through on-site visits, written reports or technical assistance. Probational certification issued for 270 calendar days will not be renewed or extended and will require a full on-site follow-up review to be completed. The provider will be required to achieve at least a one-year certification status at the time of the follow-up review in order to maintain certification.

d. During the course of the review, if a department team member encounters a situation that places a member in immediate jeopardy, the department team member will immediately notify the provider and other team members. "Immediate jeopardy" refers to circumstances where the life, health, or safety of a member will be severely jeopardized if the circumstances are not immediately corrected.

(1) The provider shall correct the situation within 24 to 48 hours. If the situation is not corrected within the prescribed time frame, that portion of the provider's services that was the subject of the notification will not be certified. The department shall immediately discontinue funding for that provider's service.

(2) If this action is appealed and the member, legal guardian, or attorney-in-fact under a durable power of attorney for health care wants to maintain the provider's services, funding can be reinstated. At that time, the provider shall take appropriate action to ensure the life, health, and safety of the members deemed to be at risk as a result of the provider's inaction.

e. As a mandatory reporter, each department team member will be required to follow appropriate procedure in all cases where a condition reportable to child and adult protective services is observed.

f. The department may grant an extension to the period of approval for the following reasons:

(1) A delay in the department's approval decision that is beyond the control of the provider or department.

(2) A request for an extension from a provider to permit the provider to prepare and obtain department approval of corrective actions. The department will establish the length of extensions on a case-by-case basis.

g. The department may revoke the provider's approval at any time for any of the following reasons:

(1) Findings of a site visit indicate that the provider has failed to implement the corrective actions submitted pursuant to paragraph 77.42(10) "d."

(2) The provider has failed to provide information requested pursuant to paragraph 77.42(10) "e."

(3) The provider refuses to allow the department to conduct a site visit pursuant to paragraph 77.42(10) "f."

(4) There are instances of noncompliance with the standards that were not identified from information submitted on the application.

h. An approved provider shall immediately notify the department and other interested parties of a decision to withdraw from an HCBS BI waiver service.

i. Following certification, any provider may request technical assistance from the department to bring into conformity those areas found in noncompliance with HCBS requirements. If multiple deficiencies are noted during a review, the department may require that technical assistance be provided to a provider to assist in the implementation of the provider's corrective actions. Providers may be given technical assistance as needed.

j. Appeals. Any adverse action can be appealed by the provider under 441—Chapter 2506.

77.42(10) Departmental reviews. The department will conduct reviews of compliance with standards as indicated in this chapter. This review may include on-site case record audits, administrative procedures, clinical practices, and interviews with staff, members, and board of directors consistent with the confidentiality safeguards of state and federal laws.

a. Reviews will be conducted annually with additional reviews conducted at the department's discretion.

b. Following a departmental review, the department will submit a copy of the department's determined survey report to the service provider, noting service deficiencies and strengths.

c. The service provider shall develop a plan of corrective action identifying completion time frames for each survey deficiency.

d. The provider shall submit the corrective action plan to the department and include a statement dated and signed, if applicable, by the chief administrative officer and president or chairperson of the governing body that all information submitted to the department is accurate and complete.

e. The department may request the provider to supply subsequent reports on implementation of a corrective action plan submitted pursuant to paragraphs 77.42(10) "c" and "d."

f. The department may conduct a site visit to verify all or part of the information submitted.

77.42(11) Case management service providers. Case management service provider organizations are eligible to participate in the Medicaid HCBS BI waiver program provided the case management service provider organizations meet the standards in 441—Chapter 24 and the case management service provider organizations are the department, a county or consortium of counties, or a provider under subcontract to the department or a county or consortium of counties.

77.42(12) Supported community living providers.

a. The department will certify only public or private agencies to provide the supported community living service. The department does not recognize individuals as service providers under the supported community living program.

b. Providers of services meeting the definition of foster care shall also be licensed according to applicable rules in 441—Chapters 108, 112, and 114 through 116.

c. Providers of services may employ or contract with individuals meeting the definition of foster family homes to provide supported community living services. These individuals shall be licensed according to applicable 441—Chapters 112 and 113.

d. Providers of services may employ or contract individuals meeting the definition of host home to provide supported community living services. These individuals must meet the criteria in the HCBS Waiver Manual as amended to July 1, 2026. A host home is a community-based family home setting whose owner or renter provides HCBS SCL or HCBS home-based habilitation (HBH) services to no more than two unrelated individuals who reside with the owner or renter in their primary residence and whose owner or renter is approved to provide those services as an independent contractor of a community-based SCL or HBH service agency.

e. The department will approve living units designed to serve up to four persons, except as necessary to prevent an overconcentration of supported community living units in a geographic area.

f. The department will approve a living unit designed to serve five persons if both of the following conditions are met:

(1) Approval will not result in an overconcentration of supported community living units in a geographic area.

(2) The county in which the living unit is located provides to the department in writing that the approval is needed to address one or more of the following issues:

1. The quantity of services currently available in the county is insufficient to meet the need;
2. The quantity of affordable rental housing in the county is insufficient to meet the need; or
3. Approval will result in a reduction in the size or quantity of larger congregate settings.

77.42(13) *Respite care providers.* Respite care providers meeting the criteria outlined in subrule 77.35(5) are eligible to participate.

77.42(14) *Supported employment providers.* Supported employment providers meeting the criteria outlined in subrule 77.30(10) are eligible to participate.

77.42(15) *Home and vehicle modification providers.* Home and vehicle modification providers meeting the criteria outlined in subrule 77.35(9) are eligible to participate.

77.42(16) *Personal emergency response system providers.* Personal emergency response system providers meeting the criteria outlined in subrule 77.35(10) are eligible to participate.

77.42(17) *Transportation service providers.* Transportation service providers meeting the criteria outlined in subrule 77.38(10) are eligible to participate.

77.42(18) *Specialized medical equipment providers.* The following providers may provide specialized medical equipment:

- a.* Medical equipment and supply dealers participating as providers in the Medicaid program.
- b.* Retail and wholesale businesses participating as providers in the Medicaid program that provide specialized medical equipment as described in 441—subrule 78.43(8).

77.42(19) *Adult day care providers.* Adult day care providers shall be agencies that meet the criteria outlined in subrule 77.35(3).

77.42(20) *Family training providers.* Family training providers shall be one of the following:

a. Providers certified under the community mental health center standards set forth in 441—Chapter 24 and that employ staff to provide family training who meet the definition of “qualified brain injury professional” as set forth in rule 441—83.81(249A).

b. Providers licensed as meeting the hospice standards and requirements set forth in 481—Chapter 53 or certified to meet the standards under the Medicare program for hospice programs and that employ staff who meet the definition of “qualified brain injury professional” as set forth in rule 441—83.81(249A).

c. Providers accredited under the mental health service provider standards set forth in 441—Chapter 24 and that employ staff to provide family training who meet the definition of “qualified brain injury professional” as set forth in rule 441—83.81(249A).

d. Individuals who meet the definition of “qualified brain injury professional” as set forth in rule 441—83.81(249A).

e. Agencies certified as HCBS BI waiver service providers pursuant to rule 441—77.42(249A) that employ staff to provide family training who meet the definition of a “qualified brain injury professional” as set forth in rule 441—83.81(249A).

f. Agencies that are accredited by a department-approved, nationally recognized accreditation organization as specialty brain injury rehabilitation service providers.

77.42(21) *Prevocational habilitation.* Prevocational habilitation services providers meeting the criteria outlined in subrule 77.30(9) are eligible to participate.

77.42(22) *Positive behavioral support and consultation providers.* Positive behavioral support and consultation providers shall be required to have experience with or training regarding the special needs of persons with a brain injury. In addition, the positive behavioral support and consultation providers must meet the following requirements:

a. Behavior assessment and development of an appropriate intervention plan with periodic reassessment of the appropriate intervention plan and training of staff who shall implement the appropriate intervention plan must be done by a “qualified brain injury professional” as defined in rule 441—83.81(249A). Formal assessment of the members’ intellectual and behavioral functioning must be done by a licensed psychologist or a psychiatrist who is certified by the American Board of Psychiatry.

b. Implementation of the plan and training and supervision of caregivers, including family members, must be done by behavioral aides who have been trained by a “qualified brain injury professional” as defined in rule 441—83.81(249A) and who are employees of one of the following:

(1) Agencies that are certified under the community mental health center standards set forth in 441—Chapter 24.

(2) Agencies that are licensed as meeting the hospice standards and requirements set forth in 481—Chapter 53 or that are certified to meet the standards under Medicare for hospice programs.

(3) Agencies that are accredited under the mental health service provider standards set forth in 441—Chapter 24.

(4) Home health aide providers meeting the standards outlined in subrule 77.35(2). Home health aide providers certified by Medicare shall be considered to have met these standards.

(5) HCBS BI waiver service providers certified pursuant to rule 441—77.42(249A).

(6) Agencies that are accredited by a department-approved, nationally recognized accreditation organization as specialty brain injury rehabilitation service providers.

(7) Individuals who meet the definition of “qualified brain injury professional” as defined in rule 441—83.81(249A).

77.42(23) *Attendant care providers.* Attendant care providers meeting the criteria outlined in subrule 77.35(7) are eligible to participate.

77.42(24) *Interim medical monitoring and treatment providers.* Interim medical monitoring and treatment providers meeting the criteria outlined in subrule 77.35(8) are eligible to participate.

77.42(25) *Financial management service.* Members who select the consumer choices option may work with a financial institution that meets the qualifications outlined in subrule 77.35(13).

77.42(26) *Independent support brokerage.* Members who select the consumer choices option shall work with an independent support broker who meets the qualifications outlined in subrule 77.35(14).

77.42(27) *Self-directed personal care.* Members who select the consumer choices option may choose to purchase self-directed personal care services from an individual or business that meets the requirements outlined in subrule 77.35(15).

77.42(28) *Individual-directed goods and services.* Members who select the consumer choices option may choose to purchase individual-directed goods and services from an individual or business that meets the requirements outlined in subrule 77.35(16).

77.42(29) *Self-directed community supports and employment.* Members who select the consumer choices option may choose to purchase self-directed community supports and employment from an individual or business that meets the requirements outlined in subrule 77.35(17).

441—77.43(249A) HCBS physical disability waiver service providers. HCBS physical disability waiver service providers shall meet the standards and qualifications outlined in the HCBS Waiver Provider Manual as amended to July 1, 2026. The integrated, community-based settings standards in subrule 77.30(5) apply to all HCBS physical disability waiver service providers.

77.43(1) Enrollment process. The department will conduct reviews of compliance with standards for initial enrollment. Enrollment carries no assurance that the approved provider will receive funding and may occur at any time. The department may request any information from the prospective service provider that is pertinent to arriving at an enrollment decision. This may include but is not limited to:

a. Current accreditations, evaluations, inspection reports, and reviews by regulatory and licensing agencies and associations.

b. Fiscal capacity of the prospective provider to initiate and operate the specified programs on an ongoing basis.

77.43(2) Attendant care providers. Attendant care providers meeting the criteria outlined in subrule 77.35(7) are eligible to participate.

77.43(3) Home and vehicle modification providers. Home and vehicle modification providers meeting the criteria outlined in subrule 77.35(9) are eligible to participate.

77.43(4) Personal emergency response system providers. Personal emergency response system providers meeting the criteria outlined in subrule 77.35(10) are eligible to participate.

77.43(5) Specialized medical equipment providers. Specialized medical equipment providers meeting the criteria outlined in subrule 77.42(18) are eligible to participate.

77.43(6) Transportation service providers. Transportation service providers meeting the criteria outlined in subrule 77.38(10) are eligible to participate.

77.43(7) Financial management service. Members who select the consumer choices option may work with a financial institution that meets the qualifications in subrule 77.35(13).

77.43(8) Independent support brokerage. Members who select the consumer choices option shall work with an independent support broker who meets the qualifications in subrule 77.35(14).

77.43(9) Self-directed personal care. Members who select the consumer choices option may choose to purchase self-directed personal care services from an individual or business that meets the requirements in subrule 77.35(15).

77.43(10) Individual-directed goods and services. Members who select the consumer choices option may choose to purchase individual-directed goods and services from an individual or business that meets the requirements in subrule 77.35(16).

77.43(11) Self-directed community supports and employment. Members who select the consumer choices option may choose to purchase self-directed community supports and employment from an individual or business that meets the subrule requirements in subrule 77.35(17).

77.43(12) Incident management and reporting. As a condition of participation in the medical assistance program, HCBS physical disability waiver service providers, except for providers of goods and services purchased under the consumer choices option or providers of home and vehicle modification, specialized medical equipment, personal emergency response, and transportation, must comply with the requirements of Iowa Code sections 232.69 and 235B.3 regarding the reporting of child abuse and dependent adult abuse and with the incident management and reporting requirements set forth in the HCBS Waiver Provider Manual as amended to July 1, 2026.

[ARC 0314D, IAB 5/27/26, effective 7/1/26]

441—77.44(249A) Public health agencies. A public health agency is eligible to participate in the medical assistance program when the public health agency serves as a public health entity within a local board of health jurisdiction pursuant to rule 641—77.3(137).

[ARC 0314D, IAB 5/27/26, effective 7/1/26]

441—77.45(249A) Infant and toddler program providers. An agency is eligible to participate in the medical assistance program as a provider of infant and toddler program services under rule 441—78.49(249A) if the agency:

1. Is in good standing under the infants and toddlers with disabilities program administered by the department of education, the department, and the Iowa child health specialty clinics pursuant to the interagency agreement between these agencies under Subchapter III of the federal Individuals with Disabilities Education Act (IDEA) as amended to July 1, 2026; and

2. Meets the following additional requirements.

77.45(1) Licensure. Covered services shall be provided by personnel who are licensed, endorsed, registered, recognized, or qualified as provided in this subrule and shall be within the scope of the applicable license, endorsement, registration, recognition, or qualification.

a. Personnel providing audiological or speech-language services shall be licensed by the board of speech pathology and audiology as a speech pathologist or audiologist pursuant to 481—Chapter 740.

b. Personnel providing physical therapy shall be licensed by the board of physical and occupational therapy as a physical therapist pursuant to 481—Chapter 800.

c. Personnel providing occupational therapy shall be licensed by the board of physical and occupational therapy as an occupational therapist pursuant to 481—Chapter 804.

d. Personnel providing psychological evaluations and counseling or psychotherapy services shall be:

(1) Licensed by the board of educational examiners as a mental health professional pursuant to rule 282—16.9(256);

(2) Licensed by the board of psychology as a psychologist pursuant to 481—Chapter 880;

(3) Licensed by the board of social work as a social worker pursuant to 481—Chapter 880;

(4) Licensed by the board of medicine as a physician pursuant to 481—Chapters 652 through 654; or

(5) Registered by the nursing board as an advanced registered nurse practitioner pursuant to 481—Chapter 621.

e. Personnel providing nursing services shall be licensed by the nursing board as a registered or licensed practical nurse pursuant to 481—Chapter 617 through 620.

f. Personnel providing vision services shall be:

(1) Licensed by the nursing board as a registered or licensed practical nurse pursuant to 481—Chapters 617 through 620;

(2) Licensed by the board of medicine as a physician pursuant to 481—Chapters 652 through 654; or

(3) Licensed by the board of optometry as an optometrist pursuant to 481—Chapter 760.

g. Developmental services shall be provided by personnel who meet standards established pursuant to rule 281—120.31(34CFR303).

h. Medical transportation shall be provided by licensed drivers.

i. Other services shall be provided by staff who are:

(1) Recognized as a special education paraprofessional pursuant to rule 281—41.403(256B);

(2) Endorsed by the board of educational examiners as a school psychologist pursuant to 282—subrule 27.3(2);

(3) Endorsed by the board of educational examiners as a speech-language pathologist pursuant to 282—subrule 27.3(3);

(4) Endorsed by the board of educational examiners as an orientation and mobility specialist pursuant to rule 282—22.12(256);

(5) Endorsed by the board of educational examiners as a school occupational therapist pursuant to rule 282—16.5(256);

(6) Endorsed by the board of educational examiners as a school physical therapist pursuant to rule 282—16.6(256);

(7) Endorsed by the board of educational examiners as a school nurse pursuant to rule 282—16.4(256);

(8) Endorsed by the board of educational examiners as a school social worker pursuant to rule 282—16.7(256);

(9) Licensed by the nursing board as a registered or licensed practical nurse pursuant to 481—Chapters 617 through 620; or

(10) Licensed by the board of medicine as a physician pursuant to 481—Chapters 652 through 654.

77.45(2) Documentation requirements. As a condition of participation, the provider shall be responsible for maintaining accurate and current documentation of services provided in the child's record. Documentation of all services performed is required and must include:

a. Date, time, location, and description of each service provided and identification of the individual rendering the service by name and professional or paraprofessional designation.

b. An assessment and response to interventions and services.

c. An individual family service plan (IFSP), including all changes and revisions, as developed by the service coordinator pursuant to rule 281—41.24(256B,34CFR300).

d. Documentation of progress toward achieving the child's or family's action steps and outcomes as identified in the IFSP.

[ARC 0314D, IAB 5/27/26, effective 7/1/26]

441—77.46(249A) Local education agency (LEA) services providers. School districts accredited by the department of education pursuant to 281—Chapter 12 and Iowa educational services for the blind and the Iowa school for the deaf, both of which are governed by the department of education pursuant to Iowa Code section 256.95, are eligible to participate in the medical assistance program as providers of LEA services under rule 441—78.50(249A) if the following conditions are met.

77.46(1) Licensure. Covered services shall be provided by personnel who are licensed, endorsed, registered, recognized, or qualified as provided in this subrule and shall be within the scope of the applicable license, endorsement, registration, recognition, or qualification.

a. Personnel providing audiological or speech-language services shall be licensed by the board of speech pathology and audiology as a speech pathologist or audiologist pursuant to 481—Chapter 740.

b. Personnel providing physical therapy shall be licensed by the board of physical and occupational therapy as a physical therapist pursuant to 481—Chapter 800.

c. Personnel providing occupational therapy shall be licensed by the board of physical and occupational therapy as an occupational therapist pursuant to 481—Chapter 804.

d. Personnel providing psychological evaluations and counseling or psychotherapy services shall be:

(1) Endorsed by the board of educational examiners as a school psychologist pursuant to 282—subrule 27.3(2);

(2) Licensed by the board of psychology as a psychologist pursuant to 481—Chapter 880;

(3) Licensed by the board of social work as a social worker pursuant to 481—Chapter 880;

(4) Licensed by the board of medicine as a physician pursuant to 481—Chapters 652 through 654; or

(5) Registered by the board of nursing as an advanced registered nurse practitioner pursuant to 481—Chapter 621.

e. Personnel providing nursing services shall be licensed by the nursing board as a registered or licensed practical nurse pursuant to 481—Chapters 617 through 620.

f. Personnel providing vision services shall be:

(1) Licensed by the nursing board as a registered or licensed practical nurse pursuant to 481—Chapters 617 through 620;

(2) Licensed by the board of medicine as a physician pursuant to 481—Chapters 652 through 654; or

(3) Licensed by the board of optometry as an optometrist pursuant to 481—Chapter 760.

g. Developmental services shall be provided by personnel who meet standards established pursuant to rule 281—120.13(34CFR303).

h. Medical transportation shall be provided by licensed drivers.

i. Other services shall be provided by staff who are:

- (1) Recognized as a special education paraprofessional pursuant to rule 281—41.403(256B);
- (2) Endorsed by the board of educational examiners as a school psychologist pursuant to 282—subrule 27.3(2);
- (3) Endorsed by the board of educational examiners as a speech-language pathologist pursuant to 282—subrule 27.3(3);
- (4) Endorsed by the board of educational examiners as an orientation and mobility specialist pursuant to rule 282—22.12(256);
- (5) Endorsed by the board of educational examiners as a school occupational therapist pursuant to rule 282—16.5(256);
- (6) Endorsed by the board of educational examiners as a school physical therapist pursuant to rule 282—16.6(256);
- (7) Endorsed by the board of educational examiners as a school nurse pursuant to rule 282—16.4(256);
- (8) Endorsed by the board of educational examiners as a school social worker pursuant to rule 282—16.7(256);
- (9) Licensed by the nursing board as a registered or licensed practical nurse pursuant to 481—Chapters 617 through 620; or
- (10) Licensed by the board of medicine as a physician pursuant to 481—Chapters 652 through 654.

77.46(2) Documentation requirements. As a condition of participation, the provider shall be responsible for maintaining accurate and current documentation in the child's record. Documentation of all services performed is required and must include:

- a. Date, time, duration, location, and description of each service delivered and identification of the individual rendering the service by name and professional or paraprofessional designation.
- b. An assessment and response to interventions and services.
- c. Progress toward goals in the individual education plan (IEP) or individual health plan (IHP) pursuant to 281—Chapter 41, Division VIII.

[ARC 0314D, IAB 5/27/26, effective 7/1/26]

441—77.47(249A) Indian health facilities. A health care facility operated by the U.S. Indian Health Service or under the Indian Self-Determination and Education Assistance Act (P.L. 93-638 as amended to July 1, 2026) by an “Indian tribe,” “tribal organization,” or “Urban Indian organization,” as those terms are defined in 25 U.S.C. 1603 as amended to July 1, 2026, is eligible to participate in the medical assistance program if the following conditions are met.

77.47(1) Licensure. Services must be rendered by practitioners who meet applicable professional licensure requirements.

77.47(2) Documentation. Medical records must be maintained at the same standards as are required for the applicable licensed medical practitioner.

[ARC 0314D, IAB 5/27/26, effective 7/1/26]

441—77.48(249A) HCBS children's mental health waiver service providers. HCBS children's mental health waiver services shall be rendered by provider agencies that meet the general provider standards in subrule 77.48(1) and the integrated, community-based settings standards in subrule 77.30(5) and also meet the standards in subrules 77.48(2) through 77.48(5) that are specific to the waiver services provided. A provider that is approved for the same service under another HCBS Medicaid waiver shall be eligible to enroll for that service under the children's mental health waiver.

77.48(1) General provider standards. All providers of HCBS children's mental health waiver services shall meet the following standards.

a. Fiscal capacity. Providers must demonstrate the fiscal capacity to provide services on an ongoing basis.

b. Direct care staff.

(1) Direct care staff must be at least 18 years of age.

(2) Providers must complete child abuse, dependent adult abuse, and criminal background screenings pursuant to Iowa Code section 249A.29 before employment of a staff member who will provide direct care.

(3) Direct care staff may not be the spouse of the member or the parent or stepparent of the member.

c. Outcome-based standards and quality assurance.

(1) Providers shall implement the outcome-based standards for the rights and dignity of children with serious emotional disturbance as set forth in the HCBS Waiver Provider Manual as amended to July 1, 2026.

(2) The department will conduct random quality assurance reviews to assess the degree to which the outcome-based standards have been implemented in service provision. Results of outcome-based quality assurance reviews shall be forwarded to the certifying or accrediting entity.

(3) A quality assurance review will include interviews with the member and the member's parents or legal guardian, with informed consent, and interviews with designated targeted case managers.

(4) A quality assurance review may include interviews with provider staff, review of case files, review of staff training records, review of compliance with the general provider standards in this subrule, and review of other organizational policies and procedures and documentation.

(5) Corrective action will be required if the quality assurance review demonstrates that service provision or provider policies and procedures do not reflect the outcome-based standards. Technical assistance for corrective action will be available from the department's quality assurance staff.

d. Incident management and reporting. As a condition of participation in the medical assistance program, HCBS children's mental health waiver service providers, except for providers of environmental modifications and adaptive devices, must comply with the requirements of Iowa Code sections 232.69 and 235B.3 regarding the reporting of child abuse and dependent adult abuse and must comply with incident management and reporting requirements set forth in the HCBS Waiver Provider Manual as amended to July 1, 2026.

77.48(2) *Environmental modifications, adaptive devices, and therapeutic resources providers.* The following agencies may provide environmental modifications, adaptive devices, and therapeutic resources under the children's mental health waiver:

a. A community business that:

(1) Possesses all necessary licenses and permits to operate in conformity with federal, state, and local statutes and regulations, including Iowa Code chapter 490; and

(2) Submits verification of current liability and workers' compensation insurance.

b. A retail or wholesale business that otherwise participates as a provider in the Medicaid program.

c. A home and vehicle modification provider enrolled under another HCBS Medicaid waiver.

d. A provider enrolled under the HCBS intellectual disability or BI waiver as a supported community living provider.

e. A provider enrolled under the HCBS children's mental health waiver as a family and community support services provider.

77.48(3) *Family and community support services providers.*

a. Qualified providers. The following agencies may provide family and community support services under the children's mental health waiver:

(1) Behavioral health intervention providers qualified under rule 441—77.13(249A).

(2) Community mental health centers accredited in good standing as providers of outpatient psychotherapy and counseling under 441—Chapter 24.

b. Staff training. As a condition of providing family and community support services under the children's mental health waiver, the agency shall meet the staff training requirements set forth in the HCBS Waiver Provider Manual as amended to July 1, 2026.

c. Support of crisis intervention plan. As a condition of providing services under the children's mental health waiver, a family and community support provider shall develop and implement policies and procedures for maintaining the integrity of the individualized "crisis intervention plan" as defined in rule 441—24.1(225A) that is developed by each member's interdisciplinary team as set forth in the HCBS Waiver Provider Manual as amended to July 1, 2026.

d. Intake, admission, and discharge. As a condition of providing services under the children's mental health waiver, a family and community support provider shall have written policies and procedures for intake, admission, and discharge.

77.48(4) In-home family therapy providers.

a. Qualified providers. The following agencies may provide in-home family therapy under the children's mental health waiver:

(1) Community mental health centers accredited in good standing as providers of outpatient psychotherapy and counseling under 441—Chapter 24.

(2) Mental health professionals licensed pursuant to 481—Chapter 880 or possessing an equivalent license in another state.

b. Staff training. As a condition of providing in-home family therapy under the children's mental health waiver, the agency shall meet the training requirements set forth in the HCBS Waiver Provider Manual as amended to July 1, 2026.

c. Support of crisis intervention plan. As a condition of providing services under the children's mental health waiver, an in-home family therapy provider shall develop and implement policies and procedures for maintaining the integrity of the individualized "crisis intervention plan" as defined in rule 441—24.1(225A) that is developed by each member's interdisciplinary team.

d. Intake, admission, and discharge. As a condition of providing services under the children's mental health waiver, an in-home family therapy provider shall have written policies and procedures for intake, admission, and discharge.

77.48(5) Respite care providers. Respite care providers meeting the criteria outlined in subrule 77.35(5) are eligible to participate.

[ARC 0314D, IAB 5/27/26, effective 7/1/26]

441—77.49(249A) Ordering and referring providers. A provider who provides services, including orders and referrals, to a Medicaid member shall be enrolled as a Medicaid provider as a condition of payment eligibility for services rendered to that Medicaid member. A provider who does not individually bill for services rendered due to, for example, payment arrangements with a facility or supervising provider, shall also be required to enroll. Enrollment will be for the purpose of ordering or referring items and providing professional services to Medicaid members and will not affect the provider's payment arrangements with such facilities or supervising providers.

[ARC 0314D, IAB 5/27/26, effective 7/1/26]

441—77.50(249A) Child care medical services. Child care centers are eligible to participate in the medical assistance program when they comply with the standards of 441—Chapter 109. A child care center in another state is eligible to participate when duly licensed in that state. The provider of child care medical services implements a comprehensive protocol of care that is developed in conjunction with the parent or guardian and specifies the medical, nursing, psychosocial, developmental therapies and personal care required by the medically dependent or technologically dependent child served. Nursing services must be provided.

[ARC 0314D, IAB 5/27/26, effective 7/1/26]

441—77.51(249A) Community-based neurobehavioral rehabilitation services.

77.51(1) Definitions.

“Assessment” means the review of the current functioning of the member using the service in regard to the member’s situation, needs, strengths, abilities, desires, and goals.

“Brain injury” means a diagnosis in accordance with rule 441—83.81(249A).

“Health care” means the services provided by trained and licensed health care professionals to restore or maintain the member’s health.

“Intermittent community-based neurobehavioral rehabilitation services” means services provided to a Medicaid member on an as-needed basis to support the member and the member’s family or caregivers to assist the member to increase adaptive behaviors, decrease maladaptive behaviors, and adapt and accommodate to challenging behaviors to support the member to remain in the member’s own home and community.

“Member” means a person who has been determined to be eligible for Medicaid under 441—Chapter 75.

“Neurobehavioral rehabilitation” refers to a specialized category of neurorehabilitation provided by a multidisciplinary team that has been trained in, and delivers, services individually designed to address cognitive, medical, behavioral and psychosocial challenges, as well as the physical manifestations of acquired brain injury. Services concurrently work to optimize functioning at personal, family and community levels by supporting the increase of adaptive behaviors, decrease of maladaptive behaviors and adaptation and accommodation to challenging behaviors to support a member to maximize the member’s independence in activities of daily living and ability to live in the member’s home and community.

“Program” means a set of related resources and services directed to the accomplishment of a fixed set of goals for eligible members.

“Standardized assessment” means a valid, reliable, and comprehensive functional assessment tool(s) or process, or both, approved by the department for use in the assessment of a member’s needs.

77.51(2) Eligible providers. The following agencies may provide community-based neurobehavioral rehabilitation residential and intermittent services:

a. An organization that is accredited by a department-approved, nationally recognized accreditation organization as a specialty brain injury rehabilitation service provider.

b. Agencies not accredited by a department-approved, nationally recognized accreditation organization as a specialty brain injury rehabilitation service provider that have applied for accreditation within the last 16 months to provide services may be enrolled. However, an organization that has not received accreditation within 16 months after application shall no longer be a qualified provider.

77.51(3) Provider standards. All community-based neurobehavioral rehabilitation service providers shall meet the following criteria:

a. The organization meets the outcome-based standards for community-based neurobehavioral rehabilitation service providers as follows:

(1) The organization shall provide high-quality supports and services to members.

(2) The organization shall have a defined mission commensurate with members’ needs, desires, and abilities.

(3) The organization shall be fiscally sound and shall establish and maintain fiscal accountability.

(4) The program administrator shall be a CBIST through the ACBIS or a CBIS under the direct supervision of a CBIST or a qualified brain injury professional as defined in rule 441—83.81(249A) with additional certification as approved by the department. The administrator shall be present in the assigned location for 25 hours per week. In the event of an absence from the assigned location exceeding four weeks, the organization shall designate a qualified replacement to act as administrator for the duration of the assigned administrator’s absence.

(5) A minimum of 75 percent of the organization’s administrative and direct care personnel shall meet one of the following criteria:

1. Have a bachelor’s degree in a human services-related field;

2. Have an associate's degree in human services with two years of experience working with individuals with brain injury;

3. Be an individual who is in the process of seeking a degree in the human services field with two years of experience working with individuals with brain injury; or

4. Be a CBIS certified through the ACBIS or have other nationally recognized brain injury certification as approved by the department.

(6) The organization shall have qualified personnel trained in the provision of direct care services to people with a brain injury. The training must be commensurate with the needs of the members served. Employees shall receive training and demonstrate competency in performing assigned duties and in all interactions with members.

b. The organization provides training and supports to its personnel. Training shall be provided before direct service provision and must be ongoing. At a minimum, the training includes the following:

- (1) Completion of the department-approved brain injury training modules.
- (2) Member rights.
- (3) Confidentiality and privacy.
- (4) Dependent adult and child abuse prevention and mandatory reporter training.
- (5) Individualized rehabilitation treatment plans.
- (6) Major mental health disorder basics.

c. Within 30 days of commencement of direct service provision, employees shall complete nationally recognized cardiopulmonary resuscitation (CPR) certification, a first-aid course, fire prevention and reaction training and universal precautions training. These training courses shall be completed no less than annually, with the exception of CPR certification, which must be renewed prior to expiration of the certification.

d. Within the first six months of commencement of direct service provision, employees shall complete training required by subparagraph 77.51(3) "a"(6).

e. Within 12 months of the commencement of direct service provision, employees shall complete a department-approved, nationally recognized certified brain injury specialist training. A majority of eligible employees within 12 months of the commencement of direct service provision shall be CBIS certified through ACBIS or have other nationally recognized brain injury certification as approved by the department.

f. The organization shall have in place an outcome management system that measures the efficiency and effectiveness of service provision, including members' preadmission location of service, length of stay, discharge location, reason for discharge, member and stakeholder satisfaction, and access to services.

g. The organization shall have in place a systematic, organization-wide, planned approach to designing, measuring, evaluating, and improving the level of its performance. The organization shall be required to:

- (1) Measure and analyze organizational activities and services quarterly.
- (2) Conduct satisfaction surveys with members, family members, employees and stakeholders, and share the information with the public.
- (3) Conduct an internal review of member service records at regular intervals.
- (4) Track major and minor incident data according to subrule 77.30(3) and unexpected occurrences involving death or serious physical or psychological injury, or the risk thereof, and analyze the data to identify trends annually to ensure the health and safety of members served by the organization.
- (5) Continuously identify areas in need of improvement.
- (6) Develop a plan to address the identified areas in need of improvement.
- (7) Implement the plan, document the results, and report to the governing body annually.

h. The organization shall have in place written policies and procedures and a personnel training program for the identification and reporting of child and dependent adult abuse to the department pursuant to 441—Chapters 175 and 176.

i. The organization's governing body shall have an active role in the administration of the organization.

j. The organization's governing body shall receive and use input from local community stakeholders, members participating in services, and employees and shall provide oversight that ensures the provision of high-quality supports and services to members.

k. The organization shall implement outcome-based standards for rights and dignity.

[ARC 0314D, IAB 5/27/26, effective 7/1/26]

441—77.52(249A) Qualified Medicare beneficiary (QMB) providers. Any Medicare provider not enrolled as an Iowa Medicaid provider for the general Medicaid population may enroll to be a QMB provider. A QMB-eligible member must meet the criteria outlined in 441—paragraph 75.6(5) “a”.

77.52(1) Reimbursement. A QMB provider may only bill the department for the QMB-eligible member's Medicare cost-sharing obligations. Reimbursement is limited to coinsurance, copayments, and deductibles for Medicare-covered services.

77.52(2) Definitions.

“*Coinsurance*” means a percentage of costs of a covered health care service that has to be paid.

“*Copayment*” means a fixed amount a member pays for a covered health care service.

“*Deductible*” means the amount paid for covered health care services before the insurance plan will effect payment.

“*Medicare cost sharing*” means the Medicare member's responsibility for a Medicare-covered service. “Medicare cost sharing” includes coinsurance, copayments, and deductibles.

“*Qualified Medicare beneficiary*” or “*QMB*” means an individual who has been determined eligible for the QMB program pursuant to 441—paragraph 75.6(5) “a.” Under the QMB program, Medicaid pays the individual's Medicare Part A and B premiums, coinsurance, copayment, and deductible (except for Part D).

[ARC 0314D, IAB 5/27/26, effective 7/1/26]

441—77.53(249A) Health insurance premium payment (HIPP) providers. Any provider not enrolled as an Iowa Medicaid provider for the general Medicaid population may enroll to be a HIPP provider. A HIPP provider may bill the department for the HIPP-eligible member's out-of-pocket, cost-sharing obligations. Reimbursement is limited to in-network coinsurance, copayments, and deductibles of the HIPP-eligible member's health insurance paid for through the HIPP program. HIPP-eligible members must meet the criteria outlined in rule 441—75.21(249A).

[ARC 0314D, IAB 5/27/26, effective 7/1/26]

441—77.54(249A) Crisis response services.

77.54(1) Definitions. The terms used in this rule shall have the same meaning as those set out in 441—Chapter 24.

77.54(2) Eligible providers. Agencies that are accredited under the mental health service provider standards set forth in 441—Chapter 24 are eligible to participate in the program by providing crisis response services, crisis stabilization community-based services, and crisis stabilization residential services.

77.54(3) Provider standards. All providers of crisis response services, crisis stabilization community-based services, and crisis stabilization residential services shall meet the standards criteria as set forth in 441—Chapter 24.

[ARC 0314D, IAB 5/27/26, effective 7/1/26]

441—77.55(249A) Subacute mental health services.

77.55(1) Definitions. The terms used in this rule shall have the same meaning as set out in Iowa Code section 135G.1.

77.55(2) Subacute mental health services. Subacute mental health services are intended to be short-term, intensive, recovery-oriented services designed to stabilize an individual who is experiencing a decreased level of functioning due to a mental health condition.

77.55(3) Eligible provider. Subacute mental health care facilities that are licensed by DIAL in accordance with 481—Chapter 71 are eligible to participate in the program by providing subacute mental health services.

77.55(4) Provider standards. All providers of subacute mental health services shall meet the standards criteria as set forth in 481—Chapter 71.

[ARC 0314D, IAB 5/27/26, effective 7/1/26]

These rules are intended to implement Iowa Code section 249A.4.

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CHAPTER 78
AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL SERVICES

[Prior to 7/1/83, Social Services[770] Ch 78]

[Prior to 2/11/87, Human Services[498]]

Chapter rescission date pursuant to Iowa Code section 17A.7: 7/1/31

441—78.1(249A) Physicians' services. Payment will be approved for all medically necessary services and supplies provided by the physician, including services rendered in the physician's office or clinic, the home, in a hospital, nursing home or elsewhere.

Payment will be made for all services rendered by a doctor of medicine or osteopathy within the scope of this practice and the limitations of state law subject to the following limitations and exclusions:

78.1(1) Payment will not be made for:

a. Drugs dispensed by a physician or other legally qualified practitioner (dentist, podiatrist, optometrist, physician associate (PA), or advanced registered nurse practitioner (ARNP)) unless it is established that there is no licensed retail pharmacy in the community in which the legally qualified practitioner's office is maintained. Rate of payment shall be established as in subrule 78.2(2), but no professional fee shall be paid. Payment will not be made for biological supplies and drugs provided free of charge to practitioners by the department.

b. Treatment of certain foot conditions as specified in paragraphs 78.15(3) "a" and "b."

c. Acupuncture treatments.

d. Unproven or experimental medical and surgical procedures. The criteria in effect in the Medicare program will be utilized in determining when a given procedure is unproven or experimental in nature.

e. Charges for surgical procedures on the "Outpatient/Same Day Surgery List" produced by Iowa Medicaid or associated inpatient care charges when the procedure is performed in a hospital on an inpatient basis unless the physician has secured approval from the hospital's utilization review department prior to the patient's admission to the hospital. Approval will be granted only when inpatient care is deemed to be medically necessary based on the condition of the patient or when the surgical procedure is not performed as a routine, primary, independent procedure. The "Outpatient/Same Day Surgery List" will be published by the department in the provider manuals for hospitals and physicians as amended to July 1, 2026. The "Outpatient/Same Day Surgery List" will be developed by Iowa Medicaid and will include procedures that can safely and effectively be performed in a doctor's office or on an outpatient basis in a hospital. Iowa Medicaid may add, delete, or modify entries on the "Outpatient/Same Day Surgery List."

f. Elective, non-medically necessary cesarean section (C-section) deliveries.

78.1(2) Drugs and supplies may be covered when prescribed by a legally qualified practitioner as provided in this rule.

a. Drugs are covered as provided by rule 441—78.2(249A).

b. Medical supplies are payable when ordered by a legally qualified practitioner for a specific rather than incidental use, subject to the conditions specified in rule 441—78.10(249A). When a member is receiving care in a nursing facility or residential care facility, payment will be approved only for the following supplies when prescribed by a legally qualified practitioner:

(1) Colostomy and ileostomy appliances.

(2) Colostomy and ileostomy care dressings, liquid adhesive and adhesive tape.

(3) Disposable irrigation trays or sets.

(4) Disposable catheterization trays or sets.

(5) Indwelling Foley catheter.

(6) Disposable saline enemas.

(7) Diabetic supplies including needles and syringes, blood glucose test strips, and diabetic urine test supplies.

c. Prescription records are required for all drugs as specified in Iowa Code sections 124.308 and 155A.27. For the purposes of the medical assistance program, prescriptions for medical supplies are required and will be subject to the same provisions.

d. In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) Program, a physician must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

78.1(3) Payment will be approved for injections provided they are reasonable, necessary, and related to the diagnosis and treatment of an illness or injury. When billing for an injection, the legally qualified practitioner must specify the brand name of the drug and the manufacturer, the strength of the drug, the amount administered, and the charge of each injection. When the strength and dosage of the drug are not included, payment will be made based on the customary dosage. The following exclusions are applicable.

a. Payment will not be approved for injections when they are considered by standards of medical practice not to be specific or effective treatment for the particular condition for which they are administered.

b. Payment will not be approved for an injection when administered for a reason other than the treatment of a particular condition, illness, or injury.

c. Payment will not be approved when injection is not an indicated method of administration according to accepted standards of medical practice.

d. Allergenic extract materials provided the patient for self-administration shall not exceed a 90-day supply.

e. Payment will not be approved when an injection is determined to fall outside of what is medically reasonable or necessary based on basic standards of medical practice for the required level of care for a particular condition.

f. Payment for vaccines available through the VFC program will be approved only if the VFC program stock has been depleted.

g. Payment will not be approved for injections of “covered Part D drugs” as defined by 42 U.S.C. Section 1395w-102(e)(1)-(2) as amended to July 1, 2026, for any “Part D eligible individual” as defined in 42 U.S.C. Section 1395w-101(a)(3)(A) as amended to July 1, 2026, including an individual who is not enrolled in a Part D plan.

78.1(4) For the purposes of this program, cosmetic, reconstructive, or plastic surgery is surgery that can be expected primarily to improve physical appearance or that is performed primarily for psychological purposes or that restores form but that does not correct or materially improve the bodily functions. When a surgical procedure primarily restores bodily function, whether or not there is also a concomitant improvement in physical appearance, the surgical procedure does not fall within the provisions set forth in this subrule. Surgeries for the purpose of sex reassignment are not considered as restoring bodily function and are excluded from coverage.

a. Coverage under the program is generally not available for cosmetic, reconstructive, or plastic surgery. However, under certain limited circumstances payment for otherwise covered services and supplies may be provided in connection with cosmetic, reconstructive, or plastic surgery as follows:

- (1) Correction of a congenital anomaly; or
- (2) Restoration of body form following an accidental injury; or
- (3) Revision of disfiguring and extensive scars resulting from neoplastic surgery.

(4) Generally, coverage is limited to those cosmetic, reconstructive, or plastic surgery procedures performed no later than 12 months subsequent to the related accidental injury or surgical trauma. However, special consideration for exception will be given to cases involving children who may require a growth period.

b. Cosmetic, reconstructive, or plastic surgery performed in connection with certain conditions is specifically excluded. These conditions are:

- (1) Dental congenital anomalies, such as absent tooth buds, malocclusion, and similar conditions.

(2) Procedures related to transsexualism, hermaphroditism, gender identity disorders, or body dysmorphic disorders. This subparagraph is intended to implement Iowa Code section 249A.14.

(3) Cosmetic, reconstructive, or plastic surgery procedures performed primarily for psychological reasons or as a result of the aging process.

(4) Breast augmentation mammoplasty, surgical insertion of prosthetic testicles, penile implant procedures, and surgeries for the purpose of sex reassignment.

c. When it is determined that a cosmetic, reconstructive, or plastic surgery procedure does not qualify for coverage under the program, all related services and supplies, including any institutional costs, are also excluded.

d. Following is a partial list of cosmetic, reconstructive, or plastic surgery procedures that are not covered under the program. This list is for example purposes only and is not considered all-inclusive.

(1) Any procedure performed for personal reasons to improve the appearance of an obvious feature or part of the body that would be considered by an average observer to be normal and acceptable for the patient's age or ethnic or racial background.

(2) Cosmetic, reconstructive, or plastic surgical procedures that are justified primarily on the basis of a psychological or psychiatric need.

(3) Augmentation mammoplasties.

(4) Facelifts and other procedures related to the aging process.

(5) Reduction mammoplasties, unless there is medical documentation of intractable pain not amenable to other forms of treatment as the result of increasingly large pendulous breasts.

(6) Panniculectomy and body sculpture procedures.

(7) Repair of sagging eyelids unless there is demonstrated and medically documented significant impairment of vision.

(8) Rhinoplasties unless there is evidence of accidental injury occurring within the past six months that resulted in significant obstruction of breathing.

(9) Chemical peeling for facial wrinkles.

(10) Dermabrasion of the face.

(11) Revision of scars resulting from surgery or a disease process, except disfiguring and extensive scars resulting from neoplastic surgery.

(12) Removal of tattoos.

(13) Hair transplants.

(14) Electrolysis.

(15) Sex reassignment.

(16) Penile implant procedures.

(17) Insertion of prosthetic testicles.

e. Coverage is available for otherwise covered services and supplies required in the treatment of complications resulting from a noncovered incident or treatment, but only when the subsequent complications represent a separate medical condition such as systemic infection, cardiac arrest, acute drug reaction, or similar conditions. Coverage will not be extended for any subsequent care or procedure related to the complication that is essentially similar to the initial noncovered care. An example of a complication similar to the initial period of care would be repair of facial scarring resulting from dermabrasion for acne.

78.1(5) The legally qualified practitioner's prescription for medical equipment, appliances, or prosthetic devices shall include the patient's diagnosis and prognosis, the reason the item is required, and an estimate in months of the duration of the need. Payment will be made in accordance with rule 441—78.10(249A).

78.1(6) Payment will be approved for the examination to establish the need for orthopedic shoes in accordance with rule 441—78.15(249A).

78.1(7) No payment will be made for the services of a private duty nurse.

78.1(8) Payment for mileage will be the same as that in effect in part B of Medicare.

78.1(9) Payment will be approved for visits to patients in nursing facilities subject to the following conditions:

a. Payment will be approved for only one visit to the same patient in a calendar month. Payment for further visits will be made only when the need for the visits is adequately documented by the physician.

b. When only one patient is seen in a single visit, the allowance will be based on a follow-up home visit. When more than one patient is seen in a single visit, payment will be based on a follow-up office visit. In the absence of information on the claim, the carrier will assume that more than one patient was seen, and payment approved on that basis.

c. Payment will be approved for mileage in connection with nursing home visits when:

(1) It is necessary for the physician to travel outside the home community, and

(2) There are not physicians in the community in which the nursing home is located.

d. Payment will be approved for tasks related to a resident receiving nursing facility care that are performed by a nurse practitioner or PA as specified in 42 CFR 483.30(f) as amended to July 1, 2026. On-site supervision of the physician is not required for these services.

78.1(10) Payment will be approved in independent laboratory when it has been certified as eligible to participate in Medicare.

78.1(11) Reserved.

78.1(12) Payment will be made on the same basis as in Medicare for services associated with treatment of chronic renal disease including physician's services, hospital care, renal transplantation, and hemodialysis, whether performed on an inpatient or outpatient basis. Payment will be made for deductibles and coinsurance for those persons eligible for Medicare.

78.1(13) Payment will be made to the physician for services rendered by auxiliary personnel employed by the physician and working under the direct personal supervision of the physician, when such services are performed incident to the physician's professional service.

a. Auxiliary personnel are nurses, psychologists, social workers, audiologists, occupational therapists and physical therapists.

b. An auxiliary person is considered to be an employee of the physician if the physician:

(1) Is able to control the manner in which the work is performed, i.e., is able to control when, where and how the work is done. This control need not be actually exercised by the physician.

(2) Sets work standards.

(3) Establishes job description.

(4) Withholds taxes from the wages of the auxiliary personnel.

c. Direct personal supervision.

(1) Direct personal supervision in the office setting means the physician must be present in the same office suite, not necessarily the same room, and be available to provide immediate assistance and direction.

(2) Direct personal supervision outside the office setting, such as the member's home, hospital, emergency room, or nursing facility, means the physician must be present in the same room as the auxiliary person.

(3) ARNPs certified under board of nursing rules in 481—Chapter 621 performing services within their scope of practice are exempt from the direct personal supervision requirement for the purpose of reimbursement to the employing physicians. In these exempted circumstances, the employing physicians must still provide general supervision and be available to provide immediate needed assistance by telephone. ARNPs who prescribe drugs and medical devices are subject to the guidelines in effect for physicians as specified in rule 441—78.1(249A).

(4) A PA licensed under board of PAs' professional licensure rules in 481—Chapters 780 through 784 is exempt from the direct personal supervision requirement, except as expressly required by Iowa Code chapter 148C or 481—Chapters 780 through 784. A physician shall be accessible at all times for consultation with a PA unless the PA is providing emergency medical services pursuant to 481—subrule 781.1(3). PAs who prescribe drugs and medical devices are subject to the guidelines in

effect for physicians as specified in rule 441—78.1(249A) or required by rules in 481—Chapters 780 through 784. PAs who prescribe drugs and medical devices are subject to the guidelines in effect for physicians as specified in rule 441—78.1(249A).

d. Services incident to the professional services of the physician means the service provided by the auxiliary person must be related to the physician's professional service to the member. If the physician has not or will not perform a personal professional service to the member, the clinical records must document that the physician assigned treatment of the member to the auxiliary person.

78.1(14) Payment will be made for persons aged 20 and under for nutritional counseling provided by a licensed dietitian employed by or under contract with a physician for a nutritional problem or condition of a degree of severity that nutritional counseling beyond that normally expected as part of the standard medical management is warranted. For persons eligible for the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), a WIC referral is required. Medical necessity for nutritional counseling services exceeding those available through WIC shall be documented.

78.1(15) The certification of inpatient hospital care will be the same as that in effect in part A of Medicare. The hospital admittance record is sufficient for the original certification.

78.1(16) No payment will be made for sterilization of an individual under the age of 21 or who is mentally incompetent or institutionalized. Payment will be made for sterilization performed on an individual who is aged 21 or older at the time the informed consent is obtained and who is mentally competent and not institutionalized when all the conditions in this subrule are met.

a. The following definitions are pertinent to this subrule:

(1) Sterilization means any medical procedure, treatment, or operation performed for the purpose of rendering an individual permanently incapable of reproducing and that is not a necessary part of the treatment of an existing illness or medically indicated as an accompaniment of an operation on the genital urinary tract. Mental illness is not considered an illness or injury.

(2) Hysterectomy means a medical procedure or operation to remove the uterus.

(3) Mentally incompetent individual means a person who has been declared mentally incompetent by a federal, state or local court of jurisdiction for any purpose unless the individual has been declared competent for purposes that include the ability to consent to sterilization.

(4) Institutionalized individual means an individual who is involuntarily confined or detained, under a civil or criminal statute, in a correctional or rehabilitative facility, including a mental hospital or other facility for the care and treatment of mental illness, or an individual who is confined under a voluntary commitment in a mental hospital or other facility for the care and treatment of mental illness.

b. The sterilization shall be performed as the result of a voluntary request for the services made by the person on whom the sterilization is performed. The person's consent for sterilization shall be documented on:

(1) A department consent form, or

(2) An official sterilization consent form from another state's Medicaid program that contains all information found on the department form and complies with all applicable federal regulations.

c. The person shall be advised prior to the receipt of consent that no benefits provided under the medical assistance program or other programs administered by the department may be withdrawn or withheld by reason of a decision not to be sterilized.

d. The person shall be informed that the consent can be withheld or withdrawn any time prior to the sterilization without prejudicing future care and without loss of other project or program benefits.

e. The person shall be given a complete explanation of the sterilization. The explanation shall include:

(1) A description of available alternative methods and the effect and impact of the proposed sterilization including the fact that it must be considered to be an irreversible procedure.

(2) A thorough description of the specific sterilization procedure to be performed and benefits expected.

(3) A description of the attendant discomforts and risks including the type and possible effects of any anesthetic to be used.

(4) An offer to answer any inquiries the person to be sterilized may have concerning the procedure to be performed. The individual shall be provided a copy of the informed consent form in addition to the oral presentation.

f. At least 30 days and not more than 180 days shall have elapsed following the signing of the informed consent, except in the case of premature delivery or emergency abdominal surgery that occurs not less than 72 hours after the informed consent was signed. The informed consent shall have been signed at least 30 days before the expected delivery date for premature deliveries.

g. The information in paragraphs 78.1(16)“*b*” through “*f*” shall be effectively presented to a blind, deaf, hard-of-hearing, or otherwise disabled individual and an interpreter shall be provided when the individual to be sterilized does not understand the language used on the consent form or used by the person obtaining consent. The individual to be sterilized may have a witness of the individual’s choice present when consent is obtained.

h. The consent form described in paragraph 78.1(16)“*b*” shall be attached to the claim for payment and shall be signed by all parties required by the form.

i. Informed consent shall not be obtained while the individual to be sterilized is:

- (1) In labor or childbirth,
- (2) Seeking to obtain or obtaining an abortion, or
- (3) Under the influence of alcohol or other substance that affects the individual’s state of awareness.

j. Payment will be made for a medically necessary hysterectomy only when it is performed for a purpose other than sterilization and only when one or more of the following conditions is met:

(1) The individual or representative has signed an acknowledgment of having been informed orally and in writing from the person authorized to perform the hysterectomy that the hysterectomy will make the individual permanently incapable of reproducing,

(2) The individual was already sterile before the hysterectomy, the physician has certified in writing that the individual was already sterile at the time of the hysterectomy, and the physician has stated the cause of the sterility, or

(3) The hysterectomy was performed as a result of a life-threatening emergency situation in which the physician determined that prior acknowledgment was not possible and the physician includes a description of the nature of the emergency.

78.1(17) Abortions. Payment for an abortion or related service is made when a Certification Regarding Abortion form is completed for the applicable circumstances and is attached to each claim for services. Payment for an abortion is made under one of the following circumstances:

a. The physician certifies that the pregnant woman’s life would be endangered if the fetus were carried to term.

b. The physician certifies that the fetus is physically deformed, mentally deficient or afflicted with a congenital illness and the physician states the medical indication for determining the fetal condition.

c. The pregnancy was the result of rape reported to a law enforcement agency or public or private health agency which may include a family physician within 45 days of the date of occurrence of the incident. The report shall include the name, address, and signature of the person making the report. The Certification Regarding Abortion form shall be signed by the person receiving the report of the rape.

d. The pregnancy was the result of incest reported to a law enforcement agency or public or private health agency including a family physician no later than 150 days after the date of occurrence. The report shall include the name, address, and signature of the person making the report. The Certification Regarding Abortion form shall be signed by the person receiving the report of incest.

78.1(18) Payment and procedure for obtaining eyeglasses, contact lenses, and visual aids shall be the same as described in rule 441—78.6(249A).

78.1(19) Preprocedure review by Iowa Medicaid will be required if payment under Medicaid is to be made for certain frequently performed surgical procedures that have a wide variation in the relative frequency the procedures are performed. Preprocedure surgical review applies to surgeries performed in hospitals (outpatient and inpatient) and ambulatory surgical centers. Approval by Iowa Medicaid will be granted only if the procedures are determined to be medically necessary based on the condition of the patient and the criteria established by Iowa Medicaid. If not so approved by Iowa Medicaid, payment will not be made under the program to the physician or to the facility in which the surgery is performed. The criteria are available from Iowa Medicaid.

78.1(20) Transplants.

a. Payment will be made only for the following organ and tissue transplant services:

(1) Kidney, cornea, skin, and bone transplants.

(2) Allogeneic stem cell transplants for the treatment of aplastic anemia, severe combined immunodeficiency disease (SCID), Wiskott-Aldrich syndrome, follicular lymphoma, Fanconi anemia, paroxysmal nocturnal hemoglobinuria, pure red cell aplasia, amegakaryocytosis/congenital thrombocytopenia, beta thalassemia major, sickle cell disease, Hurler's syndrome (mucopolysaccharidosis type 1 [MPS-1]), adrenoleukodystrophy, metachromatic leukodystrophy, refractory anemia, agnogenic myeloid metaplasia (myelofibrosis), familial erythrophagocytic lymphohistiocytosis and other histiocytic disorders, acute myelofibrosis, Diamond-Blackfan anemia, epidermolysis bullosa, or the following types of leukemia: acute myelocytic leukemia, chronic myelogenous leukemia, juvenile myelomonocytic leukemia, chronic myelomonocytic leukemia, acute myelogenous leukemia, and acute lymphocytic leukemia.

(3) Autologous stem cell transplants for treatment of the following conditions: acute leukemia; chronic lymphocytic leukemia; plasma cell leukemia; non-Hodgkin's lymphomas; Hodgkin's lymphoma; relapsed Hodgkin's lymphoma; lymphomas presenting poor prognostic features; follicular lymphoma; neuroblastoma; medulloblastoma; advanced Hodgkin's disease; primitive neuroendocrine tumor (PNET); atypical/rhabdoid tumor (ATRT); Wilms' tumor; Ewing's sarcoma; metastatic germ cell tumor; or multiple myeloma.

(4) Liver transplants for persons with extrahepatic biliary atresia or any other form of end-stage liver disease, except that coverage is not provided for persons with a malignancy extending beyond the margins of the liver.

Liver transplants require preprocedure review by Iowa Medicaid. Covered liver transplants are payable only when performed in a facility that meets the requirements of subrule 78.3(10).

(5) Heart transplants for persons with inoperable congenital heart defects, heart failure, or related conditions. Artificial hearts and ventricular assist devices as a temporary life-support system until a human heart becomes available for transplants are covered. Artificial hearts and ventricular assist devices as a permanent replacement for a human heart are not covered. Heart-lung transplants are covered where bilateral or unilateral lung transplantation with repair of a congenital cardiac defect is contraindicated.

Heart transplants, heart-lung transplants, artificial hearts, and ventricular assist devices described above require preprocedure review by Iowa Medicaid. Covered heart transplants are payable only when performed in a facility that meets the requirements of subrule 78.3(10).

(6) Lung transplants. Lung transplants for persons having end-stage pulmonary disease. Lung transplants require preprocedure review by Iowa Medicaid. Covered transplants are payable only when performed in a facility that meets the requirements of subrule 78.3(10). Heart-lung transplants are covered consistent with criteria in subparagraph 78.1(2)"a"(5).

(7) Pancreas transplants for persons with type I diabetes mellitus, as follows:

1. Simultaneous pancreas-kidney transplants and pancreas after kidney transplants are covered.
2. Pancreas transplants alone are covered for persons exhibiting any of the following:
 - A history of frequent, acute, and severe metabolic complications (e.g., hypoglycemia, hyperglycemia, or ketoacidosis) requiring medical attention.
 - Clinical problems with exogenous insulin therapy that are so severe as to be incapacitating.

- Consistent failure of insulin-based management to prevent acute complications.
- 3. The pancreas transplants listed under this subparagraph require preprocedure review by Iowa Medicaid.
- 4. Covered transplants are payable only when performed in a facility that meets the requirements of subrule 78.3(10).
- 5. Transplantation of islet cells or partial pancreatic tissue is not covered.
 - b. Donor expenses incurred directly in connection with a covered transplant are payable. Expenses incurred for complications that arise with respect to the donor are covered only if they are directly and immediately attributed to surgery. Expenses of searching for a donor are not covered.
 - c. All transplants must be medically necessary and meet other general requirements of this chapter for physician and hospital services.
 - d. Payment will not be made for any transplant not specifically listed in paragraph 78.1(20) “a.”
- 78.1(21)** Utilization review. Utilization review will be conducted for Medicaid members who access more than 24 outpatient visits in any 12-month period from physicians, ARNPs, federally qualified health centers, other clinics, and emergency rooms. For the purposes of utilization review, the term “physician” does not include a psychiatrist.
- 78.1(22)** Risk assessment. Risk assessment, using the Medicaid Prenatal Risk Assessment form, will be completed at the initial visit during a Medicaid member’s pregnancy.
 - a. If the risk assessment reflects a low-risk pregnancy, the assessment shall be completed again at approximately the twenty-eighth week of pregnancy.
 - b. If the risk assessment reflects a high-risk pregnancy, referral will be made for enhanced services. Enhanced services include health education, social services, nutrition education, and a postpartum home visit. Additional reimbursement will be provided for obstetrical services related to a high-risk pregnancy. (See description of enhanced services at subrule 78.25(3).)
- 78.1(23)** Reserved.
- 78.1(24)** Topical fluoride varnish. Payment will be made for application of an FDA-approved topical fluoride varnish, as defined by the Code on Dental Procedures and Nomenclature (CDT) published by the American Dental Association as amended to July 1, 2026, for the purpose of preventing the worsening of early childhood caries in children aged 0 to 36 months of age, when rendered by physicians or other appropriately licensed practitioners under the supervision of or in collaboration with a physician and who are acting within the scope of their practice, licensure, and other applicable state law, subject to the following provisions and limitations:
 - a. Application of topical fluoride varnish must be provided in conjunction with an early and periodic screening, diagnosis, and treatment (EPSDT) examination which includes a limited oral screening.
 - b. Separate payment will be available only for application of topical fluoride varnish, which will be at the same rate of reimbursement paid to dentists for providing this service. Separate payment for the limited oral screening will not be available, as this service is already part of and paid under the EPSDT screening examination.
 - c. Parents, legal guardians, or other authorized caregivers of children receiving application of topical fluoride varnish as part of an EPSDT screening examination shall be informed by the physician or auxiliary staff employed by and under the physician’s supervision that this application is not a substitute for comprehensive dental care.
 - d. Physicians rendering the services under this subrule shall make every reasonable effort to refer or facilitate referral of these children for comprehensive dental care rendered by a dental professional.
- 78.1(25)** Prior authorization for medication-assisted treatment will be governed pursuant to subrule 78.28(2).

441—78.2(249A) Prescribed outpatient drugs. Payment will be made for “covered outpatient drugs” as defined in 42 U.S.C. Section 1396r-8(k)(2)-(4) as amended to July 1, 2026, subject to the conditions and limitations specified in this rule.

78.2(1) *Qualified prescriber.* All drugs are covered only if prescribed or ordered by an Iowa Medicaid-enrolled practitioner licensed or registered to prescribe as specified in Iowa Code section 155A.3(39).

78.2(2) *Prescription required.* As a condition of payment for all drugs, including “nonprescription” or “over-the-counter” drugs that may otherwise be dispensed without a prescription or drug order, a prescription or drug order shall be transmitted as specified in Iowa Code sections 124.308, 155A.3 and 155A.27 by the practitioner to the pharmacy. All prescriptions or drug orders shall be available for audit by the department.

78.2(3) *Qualified source.* All drugs are covered only if marketed by manufacturers that have signed a Medicaid rebate agreement with the Secretary of Health and Human Services in accordance with Public Law 101-508 (Omnibus Budget Reconciliation Act of 1990 as amended to July 1, 2026).

78.2(4) *Prescription drugs.* Drugs that may be dispensed only upon a prescription are covered subject to the following limitations.

a. Prior authorization is required as specified in the preferred drug list published by the department pursuant to Iowa Code section 249A.20A.

(1) For any drug requiring prior authorization, reimbursement will be made for a 72-hour or three-day supply dispensed in an emergency when a prior authorization request cannot be submitted.

(2) Unless the manufacturer or labeler of a mental health prescription drug that has a significant variation in therapeutic or side effect profile from other drugs in the same therapeutic class enters into a contract to provide the state with a supplemental rebate, the drug may be placed on the preferred drug list as nonpreferred, with prior authorization required.

(3) For mental health prescription drugs requiring prior authorization that have a significant variation in therapeutic or side effect profile from other drugs in the same therapeutic class, reimbursement will be made for up to a seven-day supply pending prior authorization. A request for prior authorization shall be deemed approved if the prescriber:

1. Has on file with the department current contact information, including a current fax number, and a signed department Fax Confidentiality Certificate, and

2. Does not receive a notice of approval or disapproval within 48 hours of a request for prior authorization.

(4) Prior authorization for medication-assisted treatment will be governed pursuant to subrule 78.28(2).

b. Payment is not made for:

(1) Drugs whose prescribed use is not for a medically accepted indication as defined by Section 1927(k)(6) of the Social Security Act as amended to July 1, 2026.

(2) Drugs used for anorexia, weight gain, or weight loss.

(3) Drugs used for cosmetic purposes or hair growth.

(4) Reserved.

(5) Otherwise covered outpatient drugs if the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or the manufacturer’s designee.

(6) Drugs described in Section 107(c)(3) of the Drug Amendments of 1962 as amended to July 1, 2026, and identical, similar, or related drugs (within the meaning of Section 310.6(b)(1) of Title 21 of the Code of Federal Regulations as amended to July 1, 2026 (drugs identified through the Drug Efficacy Study Implementation (DESI) review)).

(7) “Covered Part D drugs” as defined by 42 U.S.C. Section 1395w-102(e)(1)-(2) as amended to July 1, 2026, for any “Part D eligible individual” as defined by 42 U.S.C. Section 1395w-101(a)(3)(A) as amended to July 1, 2026, including a member who is not enrolled in a Medicare Part D plan.

(8) Drugs prescribed for fertility purposes.

(9) Drugs used for the treatment of sexual or erectile dysfunction, except when used to treat a condition other than sexual or erectile dysfunction for which the drug has been approved by the U.S. Food and Drug Administration (FDA).

(10) Prescription drugs for which the prescription was executed in written (and nonelectronic) form unless the prescription was executed on a tamper-resistant pad, as required by Section 1903(i)(23) of the Social Security Act (42 U.S.C. Section 1396b(i)(23)).

(11) Drugs used for symptomatic relief of cough and colds, except for nonprescription drugs listed at subrule 78.2(5).

(12) Investigational drugs, including drugs that are the subject of an investigational new drug (IND) application allowed to proceed by the FDA but that do not meet the definition of a covered outpatient drug in 42 U.S.C. 1396r-8(k)(2)-(4) as amended to July 1, 2026.

78.2(5) *Nonprescription drugs.*

a. Nonprescription or over-the-counter (OTC) refers to a drug that may be lawfully sold without a prescription; however, Iowa Medicaid requires a prescription for covered OTC drugs. These drugs are subject to prior authorization requirements as specified in the preferred drug list (PDL) published by the department pursuant to Iowa Code section 249A.20A. The drugs are identified on the nonprescription (OTC) prescribed list by therapeutic category located on the PDL website (www.iowamedicaidpdl.com) under the PDL/PA tab.

b. Nonprescription drugs for use in a nursing facility, psychiatric medical institution for children (PMIC), or intermediate care facility for persons with an intellectual disability (ICF/ID) will be included in the per diem rate paid to the nursing facility, PMIC, or ICF/ID, with the exception of OTC insulin and pseudoephedrine.

78.2(6) *Quantity prescribed.*

a. *Quantity prescribed.* When it is not therapeutically contraindicated, the legally qualified practitioner shall prescribe not less than a one-month supply of covered prescription and nonprescription medication. Contraceptives may be prescribed in three-month quantities.

b. *Prescription refills.*

(1) Prescription refills shall be performed and recorded in a manner consistent with existent state and federal laws, rules and regulations.

(2) Automatic refills.

1. Automatic refills are allowed. Participation in an automatic refill program is voluntary and opt-in only, on a drug-by-drug basis.

2. The program must have:

- Easy-to-locate contact information through telephone, the program's website, or both;
- Easy-to-understand patient materials on how to select or unselect drug(s) for inclusion and how to disenroll;
- Confirmation that the member wants to continue in the automatic refill program at least annually;
- Confirmation of continued medical necessity provided by the Medicaid member or person acting as an authorized representative of the member, before the member receives the medication at the pharmacy or before the medication is mailed or delivered to the member, without which confirmation the drug(s) must be credited back to the Medicaid program; and
- Records of all consents, which must be in electronic or written format and must be available for review by auditors.

78.2(7) *Lowest cost item.* The pharmacist shall dispense the lowest cost item in stock that meets the requirements of the practitioner as shown on the prescription.

78.2(8) *Consultation.* In accordance with Public Law 101-508 (Omnibus Budget Reconciliation Act of 1990) as amended to July 1, 2026, a pharmacist shall offer to discuss information regarding the use of the medication with each Medicaid member or the caregiver of a member presenting a prescription. The consultation is not required if the person refuses the consultation. Standards for the content of the consultation can be found in rules of the Iowa board of pharmacy.

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441—78.3(249A) Inpatient hospital services. Payment for inpatient hospital admission is approved when it meets the criteria for inpatient hospital care as determined by Iowa Medicaid. All cases are subject to random retrospective review and may be subject to a more intensive retrospective review if abuse is suspected. In addition, transfers, outliers, and readmissions within 31 days are subject to random review. Selected admissions and procedures are subject to a 100 percent review before the services are rendered. Medicaid payment for inpatient hospital admissions and continued stays are approved when the admissions and continued stays are determined to meet the criteria for inpatient hospital care. The criteria are available from Iowa Medicaid or in local hospital utilization review offices. No payment will be made for waiver days.

See rule 441—78.31(249A) for policies regarding payment of hospital outpatient services.

If the recipient is eligible for inpatient or outpatient hospital care through the Medicare program, payment will be made for deductibles and coinsurance as set out in 441—subrule 79.1(22).

The DRG payment calculations include any special services required by the hospital, including a private room.

78.3(1) Payment for Medicaid-certified physical rehabilitation units will be approved for the day of admission but not the day of discharge or death.

78.3(2) No payment will be approved for private duty nursing.

78.3(3) Certification of inpatient hospital care shall be the same as that in effect in part A of Medicare. The hospital admittance records are sufficient for the original certification.

78.3(4) Services provided for intestinal or gastric bypass surgery for treatment of obesity require prior approval, which must be obtained by the attending physician before surgery is performed.

78.3(5) Payment will be approved for drugs provided to inpatients subject to the same provisions specified in subrule 78.2(1) and subparagraphs 78.2(4)“b”(1) through “b”(10), except for “b”(7). The basis of payment for drugs administered to inpatients is through the DRG reimbursement.

a. Payment will be approved for drugs and supplies provided to outpatients subject to the same provisions specified in subrules 78.2(1) through 78.2(4), except for subparagraph 78.2(4)“b”(7). The basis of payment for drugs provided to outpatients is through a combination of Medicaid-determined fee schedules and ambulatory payment classification, pursuant to 441—subrule 79.1(16).

b. In order to be paid for the administration of a vaccine covered under the VFC program, a hospital must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

78.3(6) Payment for nursing care provided by a hospital will be made to those hospitals certified by the department of inspections, appeals, and licensing as meeting the standards for a nursing facility.

78.3(7) Payment for inpatient hospital tests for purposes of diagnosis and treatment will be made only when the tests are specifically ordered for the diagnosis and treatment of a particular patient’s condition by the attending physician or other licensed practitioner acting within the scope of practice as defined by law, who is responsible for that patient’s diagnosis or treatment.

78.3(8) Payment will be made for medically necessary inpatient acute psychiatric intensive care services that meet the criteria in this subrule, pursuant to 441—paragraph 79.1(5)“i.” This inpatient rate is only applicable to individuals 18 to 64 years of age. All inpatient acute psychiatric intensive care services require prior authorization.

a. “Acute psychiatric intensive care” is defined as care provided for a condition with rapid onset that is accompanied by severe symptoms and is generally of brief duration, requiring emergency treatment and critical care.

b. To meet the need for acute psychiatric intensive care, the patient must:

- (1) Have a serious and persistent mental illness as defined in 441—subrule 77.25(1);
- (2) Have a current, severe, imminent risk of serious harm to self or others; and
- (3) Display additional complexity of need related to:

1. Complex comorbidities, including intellectual or developmental disability, autism spectrum disorder, substance use disorders, or traumatic brain injuries; or
2. A history of violence or current aggression that is secondary to mental illness; or
3. A request for patient transfer that has been rejected by inpatient level of care by one or more hospitals due to severity of symptoms; or
4. Lack of responsiveness to typical interventions or a condition that is treatment refractory; or
5. Disorganized psychotic state or manic thought process that impairs the ability to function or risks the safety of the patient or others; or
6. Behavior that causes disruption to the general milieu of the unit (i.e., instigating other patients in negative ways); or
7. High elopement risk; or
8. Any other atypical reason that the treating mental health provider feels that additional resources are needed to keep the patient and others around the patient safe.

c. The individual must have a documented need for acute intensive care requiring increased or specialized staffing, equipment, or facilities, based on two or more of the following:

- (1) Fall precaution protocol in place;
- (2) Restraints or seclusion room requirements;
- (3) Requiring assistance with activities of daily living;
- (4) Requirements for complex nursing care;
- (5) Acutely impaired cognitive functioning from baseline;
- (6) Documentation of interventions to address acute complex mental illness and comorbidities;
- (7) Safety protocols in place to address the physical risk posed to staff, other patients, and infrastructure;
- (8) Elopement risk precaution protocol in place.

78.3(9) Payment will be made for sterilizations in accordance with 78.1(16).

78.3(10) Payment will be approved for organ and tissue transplant services, as specified in subrule 78.1(20). Kidney, cornea, skin, bone, allogeneic bone marrow, autologous bone marrow, heart, liver, and lung transplants are covered as specified in subrule 78.1(20). Lung transplants are payable at Medicare-designated lung transplant centers only. Heart and liver transplants are payable when performed at facilities that meet the following criteria:

a. *Recipient selection and education.*

(1) *Selection.* The transplant center must have written criteria based on medical need for transplantation for final facility selection of recipients. These criteria should include an equitable, consistent and practical protocol for selection of recipients. The criteria must be at least as strict as those specified by Medicare.

(2) *Education.* The transplant center will provide a written plan for recipient education. It shall include educational plans for recipient, family and significant others during all phases of the program. These phases shall include:

Intake.

Preparation and waiting period.

Preadmission.

Hospitalization.

Discharge planning.

Follow-up.

b. *Staffing and resource commitment.*

(1) *Transplant surgeon.* The transplant center must have on staff a qualified transplant surgeon.

The surgeon must have received at least one year of training at a transplant center approved by the American Society of Transplant Surgeons under the direction of an experienced transplant surgeon and must have had at least two years of experience in all facets of transplant surgery specific to the surgeon's specialty. This experience must include management of recipients' presurgical and postsurgical care and actual experience as a member of a transplant team at the institution. The

transplant surgeon will have an understanding of the principles of and demonstrated expertise in the use of immunosuppressive therapy.

The transplant surgeon will be certified by the American Board of Thoracic Surgery or equivalent for heart transplants and the American Board of Surgery or equivalent for liver transplants.

The transplant surgeon will be the defined leader of a stable, established transplant team that has a strong commitment to the transplant program.

(2) *Transplant team.* The transplant team will be clearly defined with leadership and corresponding responsibilities of all team members identified. The team should consist of:

1. A surgeon director.
2. A board-certified internist or pediatrician with training and expertise in organ transplantation medicine and clinical use of immunosuppressive regimens.

The transplant center will assume responsibility for initial training and continuing education of the transplant team and ancillary personnel. The center will maintain records that demonstrate competency in achieving, maintaining and improving skills in the distinct areas of expertise of each of the team members.

(3) *Physicians.* The transplant center will have on staff or available for consultation physicians with the following areas of expertise:

1. Anesthesiology.
2. Cardiology.
3. Dialysis.
4. Gastroenterology.
5. Hepatology.
6. Immunology.
7. Infectious diseases.
8. Nephrology.
9. Neurology.
10. Pathology.
11. Pediatrics.
12. Psychiatry.
13. Pulmonary medicine.
14. Radiology.
15. Rehabilitation medicine.

Liaison with the recipient's permanent physician is established for the purpose of providing continuity and management of the recipient's long-term care.

(4) *Support personnel and resources.* The center must have a commitment of sufficient resources and planning for implementation and operation of the transplant program. Indicators of the commitment will include persons with expertise in the following areas available at the transplant center:

1. Anesthesiology.
2. Blood bank services.
3. Cardiology.
4. Cardiovascular surgery.
5. Dialysis.
6. Dietary services.
7. Gastroenterology.
8. Infection control.
9. Laboratory services (pathology, microbiology, immunology, tissue typing, and immunosuppressive drug monitoring).
10. Legal counsel familiar with transplantation laws and regulations.
11. Nursing service department with staff available who have expertise in the care of transplant recipients, especially in managing immunosuppressed patients and hemodynamic support.

12. Respiratory therapy.
13. Pharmaceutical services.
14. Physical therapy.
15. Psychiatry.
16. Psychosocial.

The center will have active cardiovascular, medical, and surgical programs with the ability and willingness to perform diagnostic and evaluative procedures appropriate to transplants on an emergency and ongoing basis.

The center will have designated an adequate number of intensive care and general service beds to support the transplant center.

(5) *Laboratory.* Each transplant center must have direct local 24-hour per day access to histocompatibility testing facilities. These facilities must meet the Standards for Histocompatibility Testing set forth by the Committee on Quality Assurance and Standards of the American Society for Histocompatibility and Immunogenetics (ASHI) as amended to July 1, 2026. As specified by ASHI, the director of the facility shall hold a doctoral degree in biological science, or be a physician, and subsequent to graduation shall have had four years' experience in immunology, two of which were devoted to formal training in human histocompatibility testing, documented to be professionally competent by external measures such as national proficiency testing, participation in national or international workshops or publications in peer-reviewed journals. The laboratory must successfully participate in a regional or national testing program.

c. Experience and survival rates.

(1) *Experience.* Centers will be given a minimum volume requirement of 12 heart or 12 liver transplants that should be met within one year. Due to special considerations such as patient case mix or donor availability, an additional one year conditional approval may be given if the minimum volume is not met the first year. For approval of an extrarenal organ transplant program it is highly desirable that the institution:

1. Has available a complete team of surgeons, physicians, and other specialists with specific experience in transplantation of that organ, or
2. Has an established approved renal transplant program at that institution and personnel with expertise in the extrarenal organ system itself.

(2) *Survival rates.* The transplant center will achieve a record of acceptable performance consistent with the performance and outcomes at other successful designated transplant centers. The center will collect and maintain recipient and graft survival and complication rates. A level of satisfactory success and safety will be demonstrated with bases for substantial probability of continued performance at an acceptable level. To encourage a high level of performance, transplant programs must achieve and maintain a minimum one-year patient survival rate of 70 percent for heart transplants and 50 percent for liver transplants.

d. Organ procurement. The transplant center will participate in a nationwide organ procurement and typing network. Detailed plans must exist for organ procurement yielding viable transplantable organs in reasonable numbers, meeting established legal and ethical criteria. The transplant center must be a member of the National Organ Procurement and Transplant Network.

e. Maintenance of data, research, review and evaluation.

(1) *Maintenance of data.* The transplant center will collect and maintain data on the following:

1. Risk and benefit.
2. Morbidity and mortality.
3. Long-term survival.
4. Quality of life.
5. Recipient demographic information.

These data should be compiled and maintained at the transplant center monthly. The transplant center will submit the above data to the United Network for Organ Sharing yearly.

(2) *Research.* The transplant center will have a plan for and a commitment to research. Ongoing research regarding the transplanted organs is required. The transplant center will have a program in graduate medical education or have a formal agreement with a teaching institution for affiliation with a graduate medical education program.

(3) *Review and evaluation.* The transplant center will have a plan for ongoing evaluation of the transplantation program. The transplant center will have a detailed plan for review and evaluation of recipient selection, preoperative, operative, postoperative and long-term management of the recipient. The transplant center will conduct concurrent ongoing studies to ensure high quality services are provided in the transplantation program. The transplant center will provide information to members of the transplant team and ancillary staff regarding the findings of the quality assurance studies. This information will be utilized to provide education geared toward interventions to improve staff performance and reduce complications occurring in the transplant process. The transplant center will maintain records of all quality assurance and peer review activities concerning the transplantation program to document identification of problems or potential problems, intervention, education and follow-up.

f. Application procedure. A Medicare-designated heart, liver, or lung transplant facility needs only to submit evidence of this designation to Iowa Medicaid. The application procedure for other heart and liver facilities is as follows:

(1) An original and two copies of the application must be submitted on 8½-by-11-inch paper, signed by a person authorized to do so. The facility must be a participating hospital under Medicaid and must specify its provider number, and the name and telephone number of a contact person should there be questions regarding the application.

(2) Information and data must be clearly stated, well organized and appropriately indexed to aid in its review against the criteria specified in this rule. Each page must be numbered.

(3) To the extent possible, the application should be organized into five sections corresponding to each of the five major criteria and addressing, in order, each of the subcriteria identified.

(4) The application should be mailed to Iowa Medicaid.

g. Review and approval of facilities. An organized review committee will be established to evaluate performance and survival statistics and make recommendations regarding approval as a designated transplant center based on acceptable performance standards established by the review organization and approved by the Medicaid agency.

(1) There will be established protocol for the systematic evaluation of patient outcome including survival statistics.

(2) Once a facility applies for approval and is approved as a heart or liver transplant facility for Medicaid purposes, it is obliged to report immediately to the department any events or changes that would affect its approved status. Specifically, a facility must report any significant decrease in its experience level or survival rates, the transplantation of patients who do not meet its patient selection criteria, the loss of key members of the transplant team, or any other major changes that could affect the performance of heart or liver transplants at the facility. Changes from the terms of approval may lead to withdrawal of approval for Medicaid coverage of heart or liver transplants performed at the facility.

78.3(11) Payment will be approved for inpatient hospital care rendered a patient in connection with dental treatment only when the mental, physical, or emotional condition of the patient prevents the dentist from providing this necessary care in the office.

78.3(12) Payment will be approved for an assessment fee as specified in 441—paragraphs 79.1(16)“a” and “r” to determine if a medical emergency exists. Medical emergency is defined as a sudden or unforeseen occurrence or combination of circumstances presenting a substantial risk to an individual’s health unless immediate medical treatment is given. The determination of whether a medical emergency exists will be based on the patient’s medical condition including presenting symptoms and medical history prior to treatment or evaluation.

78.3(13) Payment for patients in acute hospital beds who are determined by Iowa Medicaid to require the skilled nursing care level of care shall be made at an amount equal to the sum of the direct care rate component limit for Medicare-certified hospital-based nursing facilities pursuant to 441—paragraph 81.5(16)“f” plus the non-direct care rate component limit for Medicare-certified hospital-based nursing facilities pursuant to 441—paragraph 81.5(16)“f,” with the rate component limits being revised July 1, 2001, and every second year thereafter. This rate is effective:

- a. As of the date of notice by Iowa Medicaid that the lower level of care is required, or
- b. For the days Iowa Medicaid determines in an outlier review that the lower level of care was required.

78.3(14) Payment for patients in acute hospital beds who are determined by Iowa Medicaid to require nursing facility level of care shall be made at an amount equal to the sum of the direct care rate component limit for Medicaid nursing facilities pursuant to 441—paragraph 81.5(16)“f” plus the non-direct care rate component limit for Medicaid nursing facilities pursuant to 441—paragraph 81.5(16)“f,” with the rate component limits being revised July 1, 2001, and every second year thereafter. This rate is effective:

- a. As of the date of notice by Iowa Medicaid that the lower level of care is required, or
- b. For the days Iowa Medicaid determines in an outlier review that the lower level of care was required.

78.3(15) Payment for inpatient hospital charges associated with surgical procedures normally done and billed on an outpatient hospital basis is subject to review by Iowa Medicaid. Such reviews are based on random claim samples that are pulled on a monthly basis. If the information on a given inpatient claim included in that sample does not appear to support the appropriateness of inpatient level of care, that claim is sent to the Iowa Medicaid medical director for further review. If the medical director approves the inpatient level of care, the claim is paid. However, if the medical director determines that the care provided could have been rendered at a lower level of care, the hospital and attending physician are notified accordingly. If the hospital agrees with the finding that a lower level of care was appropriate, the hospital submits a new claim for the lower level of care. If the hospital disagrees with the lower level of care finding, the hospital can submit additional documentation for further review. The hospital or attending physician or both may appeal any final determination by Iowa Medicaid pursuant to 441—Chapter 2506.

78.3(16) Skilled nursing care in “swing beds.”

- a. Payment will be made for medically necessary skilled nursing care when provided by a hospital participating in the swing-bed program certified by the department of inspections, appeals, and licensing and approved by the U.S. Department of Health and Human Services. Payment shall be at an amount equal to the sum of the direct care rate component limit for Medicare-certified hospital-based nursing facilities pursuant to 441—paragraph 81.5(16)“f” and the non-direct care rate component limit for Medicare-certified hospital-based nursing facilities pursuant to 441—paragraph 81.5(16)“f” with the rate component limits being revised July 1, 2001, and every second year thereafter. Swing-bed placement is only intended to be short-term in nature.

- b. Any payment for skilled nursing care provided in a hospital with a certified swing-bed program, for either initial admission or continued stay, will require prior authorization, subject to the following requirements:

- (1) The hospital has fewer than 100 beds, excluding beds for newborns and intensive care.
- (2) The hospital has an existing certification for a swing-bed program, pursuant to paragraph 78.3(16)“a.”
- (3) The member is being admitted for nursing facility or skilled level of care (if the member has Medicare and skilled coverage has been exhausted).
- (4) As part of the discharge planning process for a member requiring ongoing skilled nursing care, the hospital must:

1. Complete a level of care (LOC) determination describing a member’s LOC needs, using a department Swing Bed Certification form.

2. Contact skilled nursing facilities within a 30-mile radius of the hospital regarding available beds to meet the member's LOC needs.

3. Certify that no freestanding skilled nursing facility beds are available for the member within a 30-mile radius of the hospital, which will be able to appropriately meet the member's needs and that home-based care for the member is not available or appropriate.

(5) Swing-bed stays beyond 14 days will only be approved when there is no appropriate freestanding nursing facility bed available within a 30-mile radius and home-based care for the member is not available or appropriate, as documented by the hospital seeking the swing-bed admission. For the purpose of these criteria, an "appropriate" nursing facility bed is a bed in a Medicaid-participating freestanding nursing facility that provides the LOC required for the member's medical condition and corresponding LOC needs.

(6) A Medicaid member who has been in a swing bed beyond 14 days must be discharged to an appropriate nursing facility bed within a 30-mile radius of the swing-bed hospital or to appropriate home-based care within 72 hours of an appropriate nursing facility bed becoming available.

Preadmission screening and resident review (PASRR) rules still apply for members being transferred to a nursing facility.

78.3(17) Reserved.

78.3(18) Preprocedure review by Iowa Medicaid is required if hospitals are to be reimbursed for certain frequently performed surgical procedures as set forth under subrule 78.1(19). Preprocedure review is also required for other types of major surgical procedures, such as organ transplants. Criteria are available from Iowa Medicaid.

[ARC 0315D, IAB 5/27/26, effective 7/1/26]

441—78.4(249A) Dental services. Payment is authorized only for medically necessary dental and oral surgery services provided by a dentist to the extent these services are permitted to be performed under state law either by doctors of medicine, osteopathy, dental surgery or dental medicine and would be covered if furnished by doctors of medicine or osteopathy. Services must be reasonable, necessary, and cost-effective for the prevention, diagnosis, and treatment of dental disease or injuries or for oral devices necessary for a medical condition. Payment will also be made for the following dental procedures.

78.4(1) *Preventive services.* Payment will be made for the following preventive services:

a. Oral prophylaxis, including necessary scaling and polishing, once in a six-month period except for persons who, because of a physical or mental condition, need more frequent care. Documentation supporting the need for oral prophylaxis performed more than once in a six-month period must be maintained.

b. Topical application of fluoride, once every 90 days. (This does not include the use of fluoride prophylaxis paste as fluoride treatment.)

c. Pit and fissure sealants for placement on deciduous and permanent posterior teeth only. Reimbursement for sealants is restricted to work performed on members through 18 years of age and on members who have a physical or mental condition that impairs their ability to maintain adequate oral hygiene. Replacement sealants are covered when medically necessary, as documented in the patient record.

d. Space management services in mixed dentition when premature loss of teeth would permit existing teeth to shift and cause a handicapping malocclusion, or there is too little dental ridge to accommodate either the number or the size of teeth and significant dental disease will result if the condition is not corrected.

78.4(2) *Diagnostic services.* Payment will be made for the following diagnostic services:

a. A comprehensive oral evaluation once per member per dental practice in a three-year period when the member has not been seen by a dentist in the dental practice during the three-year period.

b. A periodic oral examination once in a six-month period.

c. A full mouth radiograph survey, consisting of a minimum of 14 periapical films and bite-wing films, or a panoramic radiograph with bite-wings once in a five-year period, except when medically necessary to evaluate development and to detect anomalies, injuries and diseases. Full mouth radiograph surveys are not payable under the age of six except when medically necessary. A panographic-type radiography with bite-wings is considered the same as a full mouth radiograph survey.

- d. Supplemental bite-wing films only once in a 12-month period.
- e. Single periapical films when necessary.
- f. Intraoral radiograph, occlusal.
- g. Extraoral radiograph.
- h. Posterior-anterior and lateral skull and facial bone radiograph, survey film.
- i. Temporomandibular joint radiograph.
- j. Cephalometric film.
- k. Diagnostic casts only for orthodontic cases or dental implants or when requested by Iowa Medicaid.

l. Cone beam images when medically necessary for situations including but not limited to detection of tumors, positioning of severely impacted teeth, supernumerary teeth or dental implants.

78.4(3) Restorative services. Payment will be made for the following restorative services:

a. Treatment of dental caries in those areas that require immediate attention. Restoration of incipient or nonactive carious lesions are not payable. Carious activity may be considered incipient when there is no penetration of the dento-enamel junction as demonstrated in diagnostic radiographs.

b. Amalgam alloy and composite resin-type filling materials only once for the same restoration in a two-year period.

c. Crowns when there is at least a fair prognosis for maintaining the tooth as determined by Iowa Medicaid and when a more conservative procedure would not be serviceable.

(1) Stainless steel crowns are limited to primary and permanent posterior teeth and are covered when coronal loss of tooth structure does not allow restoration with an amalgam or composite restoration. Placement on permanent posterior teeth is allowed only for members who have a mental or physical condition that limits their ability to tolerate the procedure for placement of a different crown.

(2) Aesthetic coated stainless steel crowns and stainless steel crowns with a resin window are limited to primary anterior teeth.

(3) Laboratory-fabricated crowns, other than stainless steel, are limited to permanent teeth and require prior authorization. Approval will be granted when coronal loss of tooth structure does not allow restoration with an amalgam or composite restoration or when there is evidence of recurring decay surrounding a large existing restoration, a fracture, a broken cusp(s), or an endodontic treatment.

(4) Crowns with noble or high noble metals require prior authorization. Approval will be granted for members who meet the criteria for a laboratory-fabricated crown, other than stainless steel, and who have a documented allergy to all other restorative materials.

d. Cast post and core, post and composite or post and amalgam in addition to a crown when a tooth is functional and the integrity of the tooth would be jeopardized by no post support.

e. The following restoration procedures, as indicated:

(1) Amalgam or acrylic buildups, including any pins, are considered a core buildup.

(2) One, two, or more restorations on one surface of a tooth will be paid as a one-surface restoration (i.e., mesial occlusal pit and distal occlusal pit of a maxillary molar or mesial and distal occlusal pits of a lower bicuspid).

(3) Occlusal lingual groove of a maxillary molar that extends from the distal occlusal pit and down the distolingual groove will be paid as a two-surface restoration. This restoration and a mesial occlusal pit restoration on the same tooth will be paid as one, two-surface restoration.

(4) Two separate one-surface restorations are payable as a two-surface restoration (i.e., an occlusal pit restoration and a buccal pit restoration are a two-surface restoration).

(5) Tooth preparation, temporary restorations, cement bases, pulp capping, impressions, and local anesthesia are included in the restorative fee and may not be billed separately.

(6) Pin retention will be paid on a per-tooth basis and in addition to the final restoration.

(7) More than four surfaces on an amalgam restoration will be reimbursed as a “four-surface” amalgam.

(8) An amalgam or composite restoration is not payable following a sedative filling in the same tooth unless the sedative filling was placed more than 30 days previously.

78.4(4) *Periodontal services.* Payment may be made for the following periodontal services:

a. Full-mouth debridement to enable comprehensive periodontal evaluation and diagnosis once every 24 months. This procedure is not payable on the same date of service when other prophylaxis or periodontal services are performed.

b. Periodontal scaling and root planing once every 24 months when prior approval has been received. Prior approval will be granted per quadrant when radiographs demonstrate subgingival calculus or loss of crestal bone and when the periodontal probe chart shows evidence of pocket depths of 4 mm or greater.

c. Periodontal surgical procedures including gingivoplasty, osseous surgery, and osseous allograft when prior approval has been received. Payment for these surgical procedures will be approved after periodontal scaling and root planing has been provided, a reevaluation examination has been completed, and the member has demonstrated reasonable oral hygiene. Payment is also allowed for members who are unable to demonstrate reasonable oral hygiene due to a physical or mental condition, or who exhibit evidence of gingival hyperplasia, or who have a deep carious lesion that cannot be otherwise accessed for restoration.

d. Pedicle soft tissue graft, free soft tissue graft, and subepithelial connective tissue graft with prior approval. Authorization will be granted when the amount of tissue loss is causing problems such as continued bone loss, chronic root sensitivity, complete loss of attached tissue, or difficulty maintaining adequate oral hygiene.

e. Periodontal maintenance therapy, which requires prior authorization. Approval will be granted for members who have completed periodontal scaling and root planing at least three months prior to the initial periodontal maintenance therapy and the periodontal probe chart shows evidence of pocket depths of 4 mm or greater.

f. Tissue regeneration procedures, which require prior authorization. Approval will be granted when radiographs show evidence of recession in relation to the muco-gingival junction and the bone level indicates the tooth has a fair to good long-term prognosis.

g. Localized delivery of antimicrobial agents, which requires prior authorization. Approval will be granted when at least one year has elapsed since periodontal scaling and root planing was completed, the member has maintained regular periodontal maintenance, and pocket depths remain at a moderate to severe depth with bleeding on probing. Authorization is limited to once per site every 12 months.

78.4(5) *Endodontic services.* Payment will be made for the following endodontic services:

a. Root canal treatments on permanent anterior and posterior teeth when there is presence of extensive decay, infection, draining fistulas, severe pain upon chewing or applied pressure, prolonged sensitivity to temperatures, or a discolored tooth indicative of a nonvital tooth.

b. Vital pulpotomies. Cement bases, pulp capping, and insulating liners are considered part of the restoration and may not be billed separately.

c. Surgical endodontic treatment, including an apicoectomy, performed as a separate surgical procedure; an apicoectomy, performed in conjunction with endodontic procedure; an apical curettage; a root resection; or excision of hyperplastic tissue when nonsurgical treatment has been attempted and a reasonable time of approximately one year has elapsed after which failure has been demonstrated. Surgical endodontic procedures may be indicated when:

(1) Conventional root canal treatment cannot be successfully completed because canals cannot be negotiated, debrided or obturated due to calcifications, blockages, broken instruments, severe curvatures, and dilacerated roots.

(2) Correction of problems resulting from conventional treatment, including gross underfilling, perforations, and canal blockages with restorative materials.

d. Endodontic retreatment when prior authorization has been received. Authorization for retreatment of a tooth with previous endodontic treatment will be granted when the conventional treatment has been completed, a reasonable time has elapsed since the initial treatment, and failure has been demonstrated with a radiograph and narrative history. A reasonable period of time is approximately one year if the treating dentist is the same and may be less if the member must see a different dentist.

78.4(6) *Oral surgery—medically necessary.* Payment will be made for medically necessary oral surgery services furnished by dentists to the extent that these services may be performed under state law either by doctors of medicine, osteopathy, dental surgery or dental medicine and would be covered if furnished by doctors of medicine or osteopathy as defined in rule 441—78.1(249A). These services will be reimbursed in a manner consistent with the physician's reimbursement policy. The following surgical procedures are also payable when performed by a dentist:

- a.* Extractions, both surgical and nonsurgical.
- b.* Impaction (soft tissue impaction, upper or lower) that requires an incision of overlying soft tissue and the removal of the tooth.
- c.* Impaction (partial bony impaction, upper or lower) that requires incision of overlying soft tissue, elevation of a flap, removal of bone and removal of the tooth.
- d.* Impaction (complete bony impaction, upper or lower) that requires incision of overlying soft tissue, elevation of a flap, removal of bone and section of the tooth for removal.
- e.* Root recovery (surgical removal of residual root).
- f.* Oral antral fistula closure (or antral root recovery).
- g.* Surgical exposure of impacted or unerupted tooth for orthodontic reasons, including ligation when indicated.
- h.* Surgical exposure of impacted or unerupted tooth to aid eruption.
- i.* Postoperative care where need is shown to be beyond normal follow-up care or for postoperative care where the original service was performed by another dentist.

Routine postoperative care is considered part of the fee for surgical procedures and may not be billed separately.

78.4(7) *Prosthetic services.* Payment may be made for the following prosthetic services:

- a.* An immediate denture or a first-time complete denture. Six months' postdelivery care is included in the reimbursement for the denture.
- b.* A removable partial denture replacing anterior teeth when prior approval has been received. Approval will be granted when radiographs demonstrate adequate space for replacement of a missing anterior tooth. Six months' postdelivery care is included in the reimbursement for the denture.
- c.* A removable partial denture replacing posterior teeth including six months' postdelivery care when prior approval has been received. Approval will be granted when the member has fewer than eight posterior teeth in occlusion, excluding third molars, or the member has a full denture in one arch and a partial denture replacing posterior teeth is required in the opposing arch to balance occlusion. When one removable partial denture brings eight posterior teeth in occlusion, no additional removable partial denture will be approved. Six months' postdelivery care is included in the reimbursement for the denture.
- d.* A fixed partial denture (including an acid etch fixed partial denture) replacing anterior teeth when prior approval has been received. Approval will be granted for members who:
 - (1) Have a physical or mental condition that precludes the use of a removable partial denture, or
 - (2) Have an existing bridge that needs replacement due to breakage or extensive, recurrent decay.

High noble or noble metals will be approved only when the member is allergic to all other restorative materials.

e. A fixed partial denture replacing posterior teeth when prior approval has been received. Approval will be granted for members who meet the criteria for a removable partial denture and:

- (1) Have a physical or mental condition that precludes the use of a removable partial denture, or
- (2) Have a full denture in one arch and a partial fixed denture replacing posterior teeth is required in the opposing arch to balance occlusion.

High noble or noble metals will be approved only when the member is allergic to all other restorative materials.

f. Obturator for surgically excised palatal tissue or deficient velopharyngeal function of cleft palate patients.

g. Chairside relines and laboratory-processed relines only once per prosthesis every 12 months, beginning 6 months after placement of the denture.

h. Tissue conditioning twice per prosthesis in a 12-month period.

i. Two repairs per prosthesis in a 12-month period.

j. Adjustments to a complete or removable partial denture when medically necessary after six months' postdelivery care. An adjustment consists of removal of acrylic material or adjustment of teeth to eliminate a sore area or to make the denture fit better. Warming dentures and massaging them for better fit or placing them in a sonic device does not constitute an adjustment.

k. Dental implants and related services when prior authorization has been received. Prior authorization will be granted when the member is missing significant oral structures due to cancer, traumatic injuries, or developmental defects such as cleft palate and cannot use a conventional denture.

l. Replacement of complete or partial dentures in less than a five-year period, which requires prior authorization. Approval will be granted once per denture replacement per arch in a five-year period when the denture has been lost, stolen or broken beyond repair or cannot be adjusted for an adequate fit. Approval will also be granted for more than one denture replacement per arch within five years for members who have a medical condition that necessitates thorough mastication. Approval will not be granted in less than a five-year period when the reason for replacement is resorption.

m. A complete or partial denture rebase, which requires prior approval. Approval will be granted when the acrylic of the denture is cracked or has had numerous repairs and the teeth are in good condition.

n. An oral appliance for obstructive sleep apnea, which requires prior approval and must be custom-fabricated. Approval will be granted in accordance with Medicare criteria.

78.4(8) Orthodontic procedures. Payment may be made for the following orthodontic procedures:

a. Minor treatment to control harmful habits when prior approval has been received. Approval will be granted when it is cost-effective to lessen the severity of a malformation such that extensive treatment is not required.

b. Interceptive orthodontic treatment of the transitional dentition when prior approval has been received. Approval will be granted when it is cost-effective to lessen the severity of a malformation such that extensive treatment is not required.

c. Comprehensive orthodontic treatment when prior approval has been received. Approval is limited to members under 21 years of age and will be granted when the member has a severe handicapping malocclusion as defined by the department and when determined to be medically necessary.

78.4(9) Adjunctive general services. Payment may be made for the following:

a. Treatment in a hospital. Payment will be approved for dental treatment rendered to a hospitalized member only when the mental, physical, or emotional condition of the member prevents the dentist from providing necessary care in the office.

b. Treatment in a nursing facility. Payment will be approved for dental treatment provided in a nursing facility. When more than one patient is examined during the same nursing home visit, payment will be made by the Medicaid program for only one visit to the nursing home.

c. Office visit. Payment will be approved for an office visit for care of injuries or abnormal conditions of the teeth or supporting structure when treatment procedures or examinations are not billed for that visit.

d. Office calls after hours. Payment will be approved for office calls after office hours in emergency situations. The office call will be paid in addition to treatment procedures.

e. Drugs. Payment will be made for drugs dispensed by a dentist only if there is no licensed retail pharmacy in the community where the dentist's office is located. Payment will not be made for writing prescriptions.

f. Anesthesia. General anesthesia, intravenous sedation, and nonintravenous conscious sedation are payable services when the extensiveness of the procedure indicates it or there is a concomitant disease or impairment that warrants use of anesthesia. Inhalation of nitrous oxide is payable when the age or physical or mental condition of the member necessitates the use of minimal sedation for dental procedures.

g. Occlusal guard. A removable dental appliance to minimize the effects of bruxism and other occlusal factors requires prior approval. Approval will be granted when the documentation supports evidence of significant loss of tooth enamel, tooth chipping, headaches or jaw pain.

78.4(10) *Orthodontic services to members 21 years of age or older.* Orthodontic procedures are not covered for members 21 years of age or older.

78.4(11) *Emergency services.* Payment will be made for emergency services as defined in and pursuant to the requirements set forth in 42 CFR 438.114 as amended to July 1, 2026.

78.4(12) *Prior authorization.* Certain dental services require prior authorization as set forth in this rule. Covered dental service categories requiring prior approval are further defined and outlined in the Iowa Medicaid Dental Services Provider Manual as amended to July 1, 2026.

78.4(13) *Service setting.* When dental services cannot be safely performed in a dental office, they may be provided in a hospital or ambulatory surgical center and reimbursed in accordance with rule 441—78.26(249A).

78.4(14) *Compliance.* Payment requires compliance with Iowa Medicaid policies, clinical criteria, and documentation requirements as specified in the Iowa Medicaid Dental Services Provider Manual as amended to July 1, 2026.

78.4(15) *Annual benefit maximum.*

a. Members 21 years of age or older have an annual benefit maximum of \$1,000 per state fiscal year for coverage of dental services set forth in this rule. Payment for services exceeding the \$1,000 annual benefit maximum is the responsibility of the member.

b. The following services do not count toward the annual benefit maximum:

- (1) Preventive services;
- (2) Diagnostic services;
- (3) Fabrication of removable dentures and related services;
- (4) Anesthesia when provided in conjunction with oral surgery codes approved for payment; or
- (5) Emergency services.

[ARC 0315D, IAB 5/27/26, effective 7/1/26]

441—78.5(249A) Podiatrists. Payment will be approved only for certain podiatric services.

78.5(1) Payment will be approved for the following orthotic appliances and treatment of nail pathologies:

- a. Durable plantar foot orthotic.
- b. Plaster impressions for foot orthotic.
- c. Molded digital orthotic.
- d. Shoe padding when appliances are not practical.

e. Custom molded space shoes for rheumatoid arthritis, congenital defects and deformities, neurotropic, diabetic and ischemic intractable ulcerations and deformities due to injuries.

f. Rams horn (hypertrophic) nails.

g. Onychomycosis (mycotic) nails.

78.5(2) Payment will be made for the same scope of podiatric services available through Part B of Title XVIII (Medicare) except as listed below:

a. Treatment of flatfoot. The term “flatfoot” is defined as a condition in which one or more arches have flattened out.

b. Treatment of subluxations of the foot are defined as partial dislocations or displacements of joint surfaces, tendons, ligaments, or muscles of the foot. Surgical or nonsurgical treatments undertaken for the sole purpose of correcting a subluxated structure in the foot as an isolated entity are not covered. Reasonable and necessary diagnosis of symptomatic conditions that result from or are associated with partial displacement of foot structures is a covered service. Surgical correction in the subluxated foot structure that is an integral part of the treatment of a foot injury or is undertaken to improve the function of the foot or to alleviate an induced or associated symptomatic condition is a covered service.

c. Routine foot care. Routine foot care includes the cutting or removal of corns or calluses, the trimming of nails and other hygienic and preventive maintenance care in the realm of self-care such as cleaning and soaking the feet, the use of skin creams to maintain skin tone of both ambulatory and bedfast patients and any services performed in the absence of localized illness, injury, or symptoms involving the foot.

d. Orthopedic shoes. Payment will not be made for orthopedic shoes or for any device to be worn in or attached to orthopedic shoes or other types of shoes when provided by the podiatrist. Payment will be made to the podiatrist for the examination including tests to establish the need for orthopedic shoes.

78.5(3) Prescriptions are required for drugs and supplies as specified in paragraph 78.1(2)“c.” Payment will be made for drugs dispensed by a podiatrist only if there is no licensed retail pharmacy in the community where the podiatrist’s office is located. If eligible to dispense drugs, the podiatrist should request a copy of the Prescribed Drugs Provider Manual as amended to July 1, 2026, from Iowa Medicaid. Payment will not be made for writing prescriptions.

[ARC 0315D, IAB 5/27/26, effective 7/1/26]

441—78.6(249A) Optometrists. Payment will be approved for medically necessary services and supplies provided by the optometrist within the scope of practice of optometry and the limitations of state law, subject to the following limitations and exclusions. Covered optometric services include a professional component and materials.

78.6(1) *Payable professional services.* Payable professional services are:

a. Eye examinations. The coverage of eye examinations depends on the purpose of the examination. Services are covered if the examination is the result of a complaint or symptom of an eye disease or injury. Routine eye examinations are covered once in a 12-month period. These services are rendered in the optometrist’s office or clinic, the home, a nursing facility, or other appropriate setting. Payment for mileage will be subject to the same approval and payment criteria as those in effect for Medicare Part B. The following levels of service are recognized for optometric examinations:

(1) Intermediate examination. A level of optometric or ophthalmological services pertaining to medical examination and evaluation, with initiation or continuation of a diagnostic and treatment program.

(2) Comprehensive examination. A level of optometric or ophthalmological services pertaining to medical examination and evaluation, with initiation or continuation of a diagnostic and treatment program, and a general evaluation of the complete visual system.

b. Medical services. Payment will be approved for medically necessary services and supplies within the scope of practice of the optometrist, including services rendered in the optometrist’s office

or clinic, the home, a nursing facility, or other appropriate setting. Payment for mileage will be subject to the same approval and payment criteria as those in effect for Medicare Part B.

c. Auxiliary procedures. The following auxiliary procedures and special tests are payable when performed by an optometrist. Auxiliary procedures and special tests are reimbursed as a separate procedure only when warranted by case history or diagnosis.

(1) Serial tonometry. Single tonometry is part of the intermediate and comprehensive exams and is not payable as a separate procedure as is serial tonometry.

(2) Gonioscopy.

(3) Extended ophthalmoscopy. Routine ophthalmoscopy is part of the intermediate and comprehensive examination and is not payable as a separate procedure. Generally, extended ophthalmoscopy is considered to be part of the comprehensive examination and, if performed in conjunction with that level of service, is not payable as a separate procedure.

(4) Visual fields. Gross visual field testing is part of general optometric services and is not reported separately.

(5) External photography.

(6) Fundus photography.

(7) Retinal integrity evaluation with a three-mirror lens.

d. Single vision and multifocal spectacle lens service, verification and subsequent service. When lenses are necessary, the following enumerated professional and technical optometric services are to be provided:

(1) When spectacle lenses are necessary, the following enumerated professional and technical optometric services are to be provided:

1. Ordering of corrective lenses.

2. Verification of lenses after fabrication.

3. Adjustment and alignment of completed lens order.

(2) New spectacle lenses are subject to the following limitations:

1. Up to three times for children up to one year of age.

2. Up to four times per year for children one through three years of age.

3. Once every 12 months for children four through seven years of age.

4. Once every 24 months after eight years of age when there is a change in the prescription.

(3) Spectacle lenses made from polycarbonate or equivalent material are allowed for:

1. Children through seven years of age.

2. Members with vision in only one eye.

3. Members with a diagnosis-related illness or disability where regular lenses would pose a safety risk.

e. Reserved.

f. Frame service.

(1) When a new frame is necessary, the following enumerated professional and technical optometric services are to be provided:

1. Selection and styling.

2. Sizing and measurements.

3. Fitting and adjustment.

4. Readjustment and servicing.

(2) New frames are subject to the following limitations:

1. One frame every six months is allowed for children through three years of age.

2. One frame every 12 months is allowed for children four through seven years of age.

3. When there is a covered lens change and the new lenses cannot be accommodated by the current frame.

(3) Safety frames are allowed for:

1. Children through seven years of age.

2. Members with a diagnosis-related disability or illness where regular frames would pose a safety risk or result in frequent breakage.

g. Reserved.

h. Repairs or replacement of frames, lenses or component parts. Payment will be made for service in addition to materials. The service fee shall not exceed the dispensing fee for a replacement frame. Payment will be made for replacement of glasses when the original glasses have been lost or damaged beyond repair. Replacement of lost or damaged glasses is limited to one pair of frames and two lenses once every 12 months for adults aged 21 and over, except for people with a mental or physical disability.

i. Contact lenses. Payment will be made for documented keratoconus, aphakia, high myopia, anisometropia, trauma, severe ocular surface disease, irregular astigmatism, for treatment of acute or chronic eye disease, or when the member's vision cannot be adequately corrected with spectacle lenses. Contact lenses are subject to the following limitations:

(1) Up to 16 gas permeable contact lenses are allowed for children up to one year of age.

(2) Up to eight gas permeable contact lenses are allowed every 12 months for children one through three years of age.

(3) Up to six gas permeable contact lenses are allowed every 12 months for children four through seven years of age.

(4) Two gas permeable contact lenses are allowed every 24 months for members eight years of age or older.

(5) Soft contact lenses and replacements are allowed when medically necessary.

78.6(2) *Ophthalmic materials.* Ophthalmic materials that are provided in connection with any of the foregoing professional optometric services shall provide adequate vision as determined by the optometrist and meet the following standards:

a. Corrected curve lenses, unless clinically contraindicated.

b. Standard plastic, plastic and metal combination, or metal frames.

c. Prescription standards according to the American National Standards Institute (ANSI) standards and tolerance as amended to July 1, 2026.

78.6(3) *Reimbursement.* The reimbursement for allowed ophthalmic material is subject to a fee schedule established by the department or to actual laboratory cost as evidenced by an attached invoice. Reimbursement for rose tint is included in the fee for the lenses.

a. Materials payable by fee schedule are:

(1) Spectacle lenses, single vision and multifocal.

(2) Frames.

(3) Case for glasses.

b. Materials payable at actual laboratory cost as evidenced by an attached invoice are:

(1) Contact lenses.

(2) Schroeder shield.

(3) Ptosis crutch.

(4) Safety frames.

(5) Subnormal visual aids.

(6) Photochromatic lenses.

78.6(4) *Prior authorization.* Prior authorization is required for the following:

a. A second lens correction within a 24-month period for members eight years of age and older. Approval will be given when the member's vision has at least a five-tenths diopter of change in sphere or cylinder or ten-degree change in axis in either eye.

b. Visual therapy may be authorized when warranted by case history or diagnosis for a period of time not greater than 90 days. Should continued therapy be warranted, the prior approval process will be reaccomplished, accompanied by a report showing satisfactory progress. Approved diagnoses are convergence insufficiency and amblyopia. Visual therapy is not covered when provided by opticians.

c. Subnormal visual aids where near visual acuity is at or better than 20/100 at 16 inches, 2M print. Prior authorization is not required if near visual acuity as described above is less than 20/100. Subnormal visual aids include but are not limited to hand magnifiers, loupes, telescopic spectacles, or reverse Galilean telescope systems. Payment will be actual laboratory cost as evidenced by an attached invoice.

d. Approval for photochromatic tint will be given when the member has a documented medical condition that causes photosensitivity and less costly alternatives are inadequate.

e. Approval for press-on prisms will be granted for members whose vision cannot be adequately corrected with other covered prisms.

78.6(5) *Noncovered services.* Noncovered services include but are not limited to the following services:

- a. Glasses with cosmetic gradient tint lenses or other eyewear for cosmetic purposes.
- b. Glasses for occupational eye safety.
- c. A second pair of glasses or spare glasses.
- d. Cosmetic surgery and experimental medical and surgical procedures.
- e. Sunglasses.
- f. Progressive bifocal or trifocal lenses.

[ARC 0315D, IAB 5/27/26, effective 7/1/26]

441—78.7(249A) Opticians. Payment will be approved only for certain services and supplies provided by opticians when prescribed by a physician (MD or DO) or an optometrist. Payment and procedure for obtaining services and supplies are the same as described in rule 441—78.6(249A).

[ARC 0315D, IAB 5/27/26, effective 7/1/26]

441—78.8(249A) Chiropractors. Payment will be made for the same chiropractic procedures payable under Title XVIII of the Social Security Act (Medicare).

78.8(1) *Covered services.* Chiropractic manipulative therapy (CMT) eligible for reimbursement is specifically limited by Medicaid to the manual manipulation (i.e., by use of the hands) of the spine for the purpose of correcting a subluxation demonstrated by X-ray. Subluxation means an incomplete dislocation, off-centering, misalignment, fixation, or abnormal spacing of the vertebrae.

78.8(2) *Indications and limitations of coverage.*

a. The subluxation must have resulted in a neuromusculoskeletal condition for which CMT is appropriate treatment. The symptoms must be directly related to the subluxation that has been diagnosed. The mere statement or diagnosis of “pain” is not sufficient to support the medical necessity of CMT. CMT must have a direct therapeutic relationship to the patient’s condition. No other diagnostic or therapeutic service furnished by a chiropractor is covered under the Medicaid program.

b. The neuromusculoskeletal conditions listed on the department’s website indicate whether the conditions require short-, moderate-, or long-term CMT. If the CMT utilization guidelines are exceeded, documentation supporting the medical necessity of additional CMT must be submitted with the Medicaid claim form or the claim will be denied for failure to provide information.

c. CMT is not a covered benefit when:

- (1) The maximum therapeutic benefit has been achieved for a given condition.
- (2) There is not a reasonable expectation that the continuation of CMT would result in improvement of the patient’s condition.
- (3) The CMT seeks to prevent disease, promote health and prolong and enhance the quality of life.

78.8(3) *Documenting X-ray.* An X-ray must document the primary regions of subluxation being treated by CMT.

a. The documenting X-ray must be taken at a time reasonably proximate to the initiation of CMT. An X-ray is considered to be reasonably proximate if it was taken no more than 12 months prior to or 3 months following the initiation of CMT. X-rays need not be repeated unless there is a new

condition and no payment will be made for subsequent X-rays, absent a new condition, consistent with paragraph 78.8(3) "c." No X-ray is required for pregnant women and for children aged 18 and under.

b. The X-ray films shall be labeled with the patient's name and date the X-rays were taken and shall be marked right or left. The X-ray shall be made available to the department or its duly authorized representative when requested. A written and dated X-ray report, including interpretation and diagnosis, shall be present in the patient's clinical record.

c. Chiropractors will be reimbursed for documenting X-rays at the physician fee schedule rate. Payable X-rays will be limited to those Current Procedural Terminology (CPT) procedure codes that are appropriate to determine the presence of a subluxation of the spine. Consistent with CPT, chiropractors may bill the professional, technical, or professional and technical components for X-rays, as appropriate. Payment for documenting X-rays will be further limited to one per condition, consistent with the provisions of paragraph 78.8(3) "a." A claim for a documenting X-ray related to the onset of a new condition is only payable if the X-ray is reasonably proximate to the initiation of CMT for the new condition, as defined in paragraph 78.8(3) "a." A chiropractor is also authorized to order a documenting X-ray whether or not the chiropractor owns or possesses X-ray equipment in the chiropractor's office. Any X-rays so ordered will be payable to the X-ray provider, consistent with the provisions in this paragraph.

[ARC 0315D, IAB 5/27/26, effective 7/1/26]

441—78.9(249A) Home health agencies. Payment will be approved for medically necessary home health agency services prescribed by a physician, nurse practitioner, clinical nurse specialist, or PA in a plan of home health care provided by a Medicare-certified home health agency.

1. The number of hours of home health agency services shall be reasonable and appropriate to meet an established medical need of the member that cannot be met by a family member, significant other, friend, or neighbor. Services must be medically necessary in the individual case and be related to a diagnosed medical impairment or disability.

2. The member need not be homebound to be eligible for home health agency services; however, the services provided by a home health agency will only be covered when provided in the member's residence with the following exception. Private duty nursing and personal care services for persons aged 20 and under as described at paragraph 78.9(10) "a" may be provided in settings other than the member's residence when medically necessary.

3. Medicaid members of home health agency services need not first require skilled nursing care to be entitled to home health aide services.

4. Further limitations related to specific components of home health agency services are noted in subrules 78.9(3) through 78.9(10).

5. Payment will be made on an encounter basis. An encounter is defined as separately identifiable hours in which home health agency staff provide continuous service to a member.

6. Dressings, durable medical equipment, and other supplies shall be obtained from a durable medical equipment dealer or pharmacy.

7. Payment may be made for restorative and maintenance home health agency services.

8. Payment may be made for teaching, training, and counseling in the provision of health care services.

9. Treatment plans for these services shall additionally reflect: to whom the services are to be provided (patient, family member, etc.); prior teaching training, or counseling provided; medical necessity for the rendered service; identification of specific services and goals; date of onset of the teaching, training, or counseling; frequency of services; progress of member in response to treatment; and estimated length of time these services will be needed.

10. The following are not covered: services provided in the home health agency office, homemaker services, well child care and supervision, and medical equipment rental or purchase.

11. Services shall be authorized by a physician, nurse practitioner, clinical nurse specialist, or PA, evidenced by the physician's, nurse practitioner's, clinical nurse specialist's, or PA's signature and date on a plan of treatment.

78.9(1) *Treatment plan.* A plan of treatment shall be completed prior to the start of care and at a minimum reviewed every 60 days thereafter. There must be a face-to-face encounter between a physician, a nurse practitioner, a clinical nurse specialist, a certified nurse-midwife, or a PA and the Medicaid member no more than 90 days before or 30 days after the start of service. The plan of care shall support the medical necessity and intensity of services to be provided by reflecting the following information:

- a. Place of service.
- b. Type of service to be rendered and the treatment modalities being used.
- c. Frequency of the services.
- d. Assistance devices to be used.
- e. Date home health services were initiated.
- f. Progress of member in response to treatment.
- g. Medical supplies to be furnished.
- h. Member's medical condition as reflected by the following information, if applicable:
 - (1) Dates of prior hospitalization.
 - (2) Dates of prior surgery.
 - (3) Date last seen by a physician, nurse practitioner, clinical nurse specialist, or PA.
 - (4) Diagnoses and dates of onset of diagnoses for which treatment is being rendered.
 - (5) Prognosis.
 - (6) Functional limitations.
 - (7) Vital signs reading.
 - (8) Date of last episode of instability.
 - (9) Date of last episode of acute recurrence of illness or symptoms.
 - (10) Medications.
- i. Discipline of the person providing the service.
- j. Certification period (no more than 60 days).
- k. Estimated date of discharge from the hospital or home health agency services, if applicable.
- l. Physician's, nurse practitioner's, clinical nurse specialist's, or PA's signature and date. The plan of care must be signed and dated by the physician, nurse practitioner, clinical nurse specialist, or PA before the claim for service is submitted for reimbursement.

78.9(2) *Supervisory visits.* Payment will be made for supervisory visits two times a month when a registered nurse acting in a supervisory capacity provides supervisory visits of services provided by a home health aide under a home health agency plan of treatment or when services are provided by an in-home health care provider under the department's in-home health-related care program as set forth in 441—Chapter 177.

78.9(3) *Skilled nursing services.* Skilled nursing services are services that when performed by a home health agency require a licensed registered nurse or licensed practical nurse to perform. Situations when a service can be safely performed by the member or other nonskilled person who has received the proper training or instruction or when there is no one else to perform the service are not considered a "skilled nursing service." Skilled nursing services shall be available only on an intermittent basis. Intermittent services for skilled nursing services are defined as a medically predictable recurring need requiring a skilled nursing service at least once every 60 days, not to exceed five days per week (except as provided below), with an attempt to have a predictable end. Daily visits (six or seven days per week) that are reasonable and necessary and show an attempt to have a predictable end will be covered for up to three weeks. Coverage of additional daily visits beyond the initial anticipated time frame may be appropriate for a short period of time, based on the medical necessity of service. Medical documentation shall be submitted justifying the need for continued visits, including the physician's, nurse practitioner's, clinical nurse specialist's, or PA's

estimate of the length of time that additional visits will be necessary. Daily skilled nursing visits or multiple daily visits for wound care or insulin injections will be covered when ordered by a physician, nurse practitioner, clinical nurse specialist, or a PA and included in the plan of care. Other daily skilled nursing visits that are ordered for an indefinite period of time and designated as daily skilled nursing care do not meet the intermittent definition and will be denied.

a. Skilled nursing services will be evaluated based on the complexity of the service and the condition of the patient.

b. Private duty nursing for persons aged 21 and over is not a covered service. See subrule 78.9(10) for guidelines for private duty nursing for persons aged 20 or under.

78.9(4) *Physical therapy services.* Payment will be made for physical therapy services when the services relate directly to an active written treatment plan, follow a treatment plan established by the physician, nurse practitioner, clinical nurse specialist, or PA after any needed consultation with the qualified physical therapist, are reasonable and necessary to the treatment of the patient's illness or injury, and meet the guidelines defined for restorative, maintenance, or trial therapy as set forth in paragraphs 78.19(1) "a" and "b."

For physical therapy services, the treatment plan shall additionally reflect goals, modalities of treatment, date of onset of conditions being treated, restorative potential, and progress notes.

78.9(5) *Occupational therapy services.* Payment will be made for occupational therapy services when the services relate directly to an active written treatment plan, follow a treatment plan established by the physician, nurse practitioner, clinical nurse specialist, or PA, are reasonable and necessary to the treatment of the patient's illness or injury, and meet the guidelines defined for restorative, maintenance, or trial therapy as set forth in paragraphs 78.19(1) "a" and "c."

For occupational therapy services, the treatment plan shall additionally reflect goals, modalities of treatment, date of onset of conditions being treated, restorative potential, and progress notes.

78.9(6) *Speech therapy services.* Payment will be made for speech therapy services when the services relate directly to an active written treatment plan, follow a treatment plan established by the physician, nurse practitioner, clinical nurse specialist, or PA, are reasonable and necessary to the treatment of the patient's illness or injury, and meet the guidelines defined for restorative, maintenance, or trial therapy as set forth in paragraphs 78.19(1) "a" and "d."

For speech therapy services, the treatment plan shall additionally reflect goals, modalities of treatment, date of onset of conditions being treated, restorative potential, and progress notes.

78.9(7) *Home health aide services.* Payment will be made for unskilled services provided by a home health aide if the following conditions are met:

a. The service as well as the frequency and duration are stated in a written plan of treatment established by a physician, nurse practitioner, clinical nurse specialist, or PA. The home health agency is encouraged to collaborate with the member, or in the case of a child with the child's caregiver, in the development and implementation of the plan of treatment.

b. The member requires personal care services as determined by a registered nurse or other appropriate therapist. The services shall be given under the supervision of a registered nurse, physical, speech, or occupational therapist and the registered nurse or therapist shall assign the aide who will provide the care.

c. Services shall be provided on an intermittent basis. "Intermittent basis" for home health agency services is defined as services that are usually two to three times a week for two to three hours at a time. Services provided for four to seven days per week, not to exceed 28 hours per week, when ordered by a physician, nurse practitioner, clinical nurse specialist, or PA and included in a plan of care will be allowed as intermittent services. Increased services provided when medically necessary due to unusual circumstances on a short-term basis of two to three weeks may also be allowed as intermittent services when the home health agency documents the need for the excessive time required for home health aide services.

(1) Home health aide daily care may be provided for persons employed or attending school whose disabling conditions require the persons to be assisted with morning and evening activities of daily living in order to support their independent living.

(2) Personal care services include the activities of daily living, e.g., helping the member to bathe, get in and out of bed, care for hair and teeth, exercise, and take medications specifically ordered by the physician, but ordinarily self-administered, and retraining the member in necessary self-help skills.

(3) Certain household services may be performed by the aide in order to prevent or postpone the member's institutionalization when the primary need of the member for home health aide services furnished is for personal care. If household services are incidental and do not substantially increase the time spent by the aide in the home, the entire visit is considered a covered service. Domestic or housekeeping services that are not related to patient care are not a covered service if personal care is not rendered during the visit.

(4) For home health aide services, the treatment plan shall additionally reflect the number of hours per visit and the living arrangement of the member, e.g., lives alone or with family.

78.9(8) Reserved.

78.9(9) *Home health agency care for maternity patients and children.* The intent of home health agency services for maternity patients and children is to provide services when the members are unable to receive the care outside of their home and require home health care due to a high-risk factor. Routine prenatal, postpartum, or child health care is a covered service in a physician's office or clinic and, therefore, is not covered by Medicaid when provided by a home health agency.

a. Treatment plans for maternity patients and children shall identify:

- (1) The potential risk factors,
- (2) The medical factor or symptom that verifies the child is at risk,
- (3) The reason the member is unable to obtain care outside of the home,
- (4) The medically related task of the home health agency,
- (5) The member's diagnosis,
- (6) Specific services and goals, and
- (7) The medical necessity for the services to be rendered. A single high-risk factor does not provide sufficient documentation of the need for services.

b. The following list of potential high-risk factors may indicate a need for home health services to prenatal maternity patients:

- (1) Aged 16 or under.
- (2) First pregnancy for a woman aged 35 or over.
- (3) Previous history of prenatal complications such as fetal death, eclampsia, C-section delivery, psychosis, or diabetes.
- (4) Current prenatal problems such as hypertensive disorders of pregnancy, diabetes, cardiac disease, sickle cell anemia, low hemoglobin, mental illness, or drug or alcohol abuse.
- (5) Sociocultural or ethnic problems such as language barriers, lack of family support, insufficient dietary practices, history of child abuse or neglect, or single mother.
- (6) Preexisting disabilities such as sensory deficits, or mental or physical disabilities.
- (7) Second pregnancy in 12 months.
- (8) Death of a close family member or significant other within the previous year.

c. The following list of potential high-risk factors may indicate a need for home health services to postpartum maternity patients:

- (1) Aged 16 or under.
- (2) First pregnancy for a woman aged 35 or over.
- (3) Major postpartum complications such as severe hemorrhage, eclampsia, or C-section delivery.
- (4) Preexisting mental or physical disabilities such as deaf, hard of hearing, blind, hemiplegic, activity-limiting disease, sickle cell anemia, uncontrolled hypertension, uncontrolled diabetes, mental illness, or intellectual disability.

- (5) Drug or alcohol abuse.
- (6) Symptoms of postpartum psychosis.
- (7) Special sociocultural or ethnic problems such as lack of job, family problems, single mother, lack of support system, or history of child abuse or neglect.
- (8) Demonstrated disturbance in maternal and infant bonding.
- (9) Discharge or release from hospital against medical advice before 36 hours postpartum.
- (10) Insufficient antepartum care by history.
- (11) Multiple births.
- (12) Nonhospital delivery.

d. The following list of potential high-risk factors may indicate a need for home health services to infants:

- (1) Birth weight of five pounds or under or over ten pounds.
- (2) History of severe respiratory distress.
- (3) Major congenital anomalies such as neonatal complications which necessitate planning for long-term follow-up such as postsurgical care, poor prognosis, home stimulation activities, or periodic development evaluation.
- (4) Disabling birth injuries.
- (5) Extended hospitalization and separation from other family members.
- (6) Genetic disorders, such as Down syndrome, and phenylketonuria or other metabolic conditions that may lead to intellectual disability.
- (7) Noted parental rejection or indifference toward baby such as never visiting or calling the hospital about the baby's condition during the infant's extended stay.
- (8) Family sociocultural or ethnic problems such as low education level or lack of knowledge of child care.
- (9) Discharge or release against medical advice before 36 hours of age.
- (10) Nutrition or feeding problems.

e. The following list of potential high-risk factors may indicate a need for home health services to preschool or school-age children:

- (1) Child or sibling victim of child abuse or neglect.
- (2) Intellectual disability or other physical disabilities necessitating long-term follow-up or major readjustments in family lifestyle.
- (3) Failure to complete the basic series of immunizations by 18 months, or boosters by 6 years.
- (4) Chronic illness such as asthma, cardiac, respiratory or renal disease, diabetes, cystic fibrosis, or muscular dystrophy.
- (5) Malignancies such as leukemia or carcinoma.
- (6) Severe injuries necessitating treatment or rehabilitation.
- (7) Disruption in family or peer relationships.
- (8) Suspected developmental delay.
- (9) Nutritional deficiencies.

78.9(10) *Private duty nursing or personal care services for persons aged 20 and under.* Payment for private duty nursing or personal care services for persons aged 20 and under will be approved if determined to be medically necessary. Payment will be made on an hourly unit of service.

a. Definitions.

(1) Private duty nursing services are those services that are provided by a registered nurse or a licensed practical nurse under the direction of the member's physician to a member in the member's place of residence or outside the member's residence, when normal life activities take the member outside the place of residence. Place of residence does not include nursing facilities, ICFs/ID, or hospitals.

1. Services shall be provided according to a written plan of care authorized by a licensed physician. The home health agency is encouraged to collaborate with the member, or in the case of a child with the child's caregiver, in the development and implementation of the plan of treatment.

These services shall exceed intermittent guidelines as defined in subrule 78.9(3). Private duty nursing and personal care services shall be inclusive of all home health agency services personally provided to the member. Enhanced payment under the interim fee schedule will be made available for services to children who are technology dependent, i.e., ventilator dependent or whose medical condition is so unstable as to otherwise require intensive care in a hospital.

2. Private duty nursing or personal care services do not include:

- Respite care, which is a temporary intermission or period of rest for the caregiver.
- Nurse supervision services including chart review, case discussion or scheduling by a registered nurse.
- Services provided to other persons in the member's household.
- Services requiring prior authorization that are provided without regard to the prior authorization process.
- Transportation services.
- Homework assistance.

(2) Personal care services are those services provided by a home health aide or certified nurse's aide and which are delegated and supervised by a registered nurse under the direction of the member's physician to a member in the member's place of residence or outside the member's residence, when normal life activities take the member outside the place of residence. Place of residence does not include nursing facilities, ICFs/ID, or hospitals. Payment for personal care services for persons aged 20 and under that exceed intermittent guidelines may be approved if determined to be medically necessary as defined in subrule 78.9(7). These services shall be in accordance with the member's plan of care and authorized by a physician. The home health agency is encouraged to collaborate with the member, or in the case of a child with the child's caregiver, in the development and implementation of the plan of treatment.

Medical necessity means the service is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent the worsening of conditions that endanger life, cause pain, result in illness or infirmity, threaten to cause or aggravate a disability or chronic illness, and no other equally effective course of treatment is available or suitable for the member requesting a service.

b. Requirements.

(1) Private duty nursing or personal care services shall be ordered in writing by a physician as evidenced by the physician's signature on the plan of care.

(2) Private duty nursing or personal care services will be authorized by the department or the department's designated review agent prior to payment.

(3) Prior authorization shall be requested at the time of initial submission of the plan of care or at any time the plan of care is substantially amended and shall be renewed with the department or the department's designated review agent. Initial request for and request for renewal of prior authorization shall be submitted to the department's designated review agent. The provider of the service is responsible for requesting prior authorization and for obtaining renewal of prior authorization.

The request for prior authorization shall include a nursing assessment, the plan of care, and supporting documentation. The request for prior authorization shall include all items previously identified as required treatment plan information and shall further include: any planned surgical interventions and projected time frame; information regarding caregiver's desire to become involved in the member's care, to adhere to program objectives, to work toward treatment plan goals, and to work toward maximum independence; and identify the types and service delivery levels of all other services to the member whether or not the services are reimbursable by Medicaid. Providers shall indicate the expected number of private duty nursing RN hours, private duty nursing LPN hours, or home health aide hours per day, the number of days per week, and the number of weeks or months of service per discipline. If the member is currently hospitalized, the projected date of discharge shall be included.

Prior authorization approvals will not be granted for treatment plans that exceed 16 hours of home health agency services per day.

78.9(11) *Vaccines.* In order to be paid for the administration of a vaccine covered under the VFC program, a home health agency must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

[ARC 0315D, IAB 5/27/26, effective 7/1/26]

441—78.10(249A) Durable medical equipment (DME), prosthetic devices and medical supplies.

78.10(1) *General payment requirements.* Payment will be made for items of DME, prosthetic devices and medical supplies, subject to the following general requirements and the requirements of subrule 78.10(2), 78.10(3), or 78.10(4), as applicable:

a. DME, prosthetic devices, and medical supplies must be required by the member because of the member's medical condition.

b. The item shall be necessary and reasonable either for the treatment of an illness or injury, or to improve the functioning of a malformed body part. Determination will be made by Iowa Medicaid.

(1) An item is necessary when it can be expected to make a meaningful contribution to the treatment of a specific illness or injury or to the improvement in function of a malformed body part.

(2) Although an item may be necessary, it must also be a reasonable expenditure for the Medicaid program. The following considerations enter into the determination of reasonableness: Whether the expense of the item to the program would be clearly disproportionate to the therapeutic benefits which could ordinarily be derived from use of the item; whether the item would be substantially more costly than a medically appropriate and realistically feasible alternative pattern of care; and whether the item serves essentially the same purpose as an item already available to the beneficiary.

c. A physician's (doctor of medicine, osteopathy, or podiatry), PA's, or ARNP's prescription is required to establish medical necessity. The prescription shall state the member's name, diagnosis, prognosis, item(s) to be dispensed, quantity, and length of time the item is to be required and shall include the signature of the prescriber and the date of signature.

For items requiring prior authorization, a request shall include a physician's, PA's, or ARNP's written order or prescription and sufficient medical documentation to permit an independent conclusion that the requirements for the equipment or device are met and the item is medically necessary and reasonable. A request for prior authorization is made using an Outpatient Prior Authorization Request form. See rule 441—78.28(249A) for prior authorization requirements.

d. Nonmedical items will not be covered. These include but are not limited to:

- (1) Physical fitness equipment, e.g., an exercycle, weights.
- (2) First-aid or precautionary-type equipment, e.g., preset portable oxygen units.
- (3) Self-help devices, e.g., safety grab bars, raised toilet seats.
- (4) Training equipment, e.g., speech teaching machines, braille training texts.
- (5) Equipment used for environmental control or to enhance the environmental setting, e.g., room heaters, air conditioners, humidifiers, dehumidifiers, and electric air cleaners.

(6) Equipment that basically serves comfort or convenience functions or is primarily for the convenience of a person caring for the member, e.g., elevators, stairway elevators and posture chairs.

e. The amount payable is based on the least expensive item that meets the member's medical needs. Payment will not be approved for items that serve duplicate functions. EXCEPTION: A second ventilator, with approved medical necessity.

f. Consideration will be given to rental or purchase based on the price of the item and the length of time it would be required. The decision on rental or purchase will be made by Iowa Medicaid and be based on the most reasonable method to provide the equipment.

(1) The provider shall monitor rental payments up to 100 percent of the purchase price. At the point that total rent paid equals 100 percent of the purchase allowance, the member will be considered to own the item and no further rental payments will be made to the provider.

(2) Payment may be made for the purchase of an item even though rental payments may have been made for prior months. The rental of the equipment may be necessary for a period of time to

establish that it will meet the identified need before the purchase of the equipment. When a decision is made to purchase after renting an item, all rental payments will be applied to the purchase allowance.

(3) EXCEPTION: Ventilators and oxygen systems shall be maintained on a rental basis for the duration of use.

(4) A deposit shall not be charged by a provider to a Medicaid member or any other person on behalf of a Medicaid member for rental of medical equipment.

g. Payment may be made for necessary repair, maintenance, and supplies for member-owned equipment. No payment may be made for repairs, maintenance, or supplies when the member is renting the item.

h. Replacement of member-owned equipment is covered in cases of loss or irreparable damage or when required because of a change in the member's condition.

i. No allowance will be made for delivery, freight, postage, or other provider operating expenses for DME, prosthetic devices or medical supplies.

j. Reimbursement over the established fee schedule amount is allowed when prior authorization has been obtained. See 78.10(5) for prior authorization requirements.

78.10(2) Durable medical equipment. DME is equipment that can withstand repeated use, is primarily and customarily used to serve a medical purpose, is generally not useful to a person in the absence of an illness or injury, and is appropriate for use in the home.

a. DME in a hospital, nursing facility, or ICF/ID is not separately payable.

EXCEPTIONS:

(1) Oxygen services in a nursing facility or an ICF/ID when all of the following requirements and conditions have been met:

1. Medical documentation or a reasonable facsimile is completed by a physician, PA, or ARNP and qualifies the member in accordance with Medicare criteria.

2. Additional documentation shows that the member requires oxygen for 12 hours or more per day for at least 30 days.

3. Oxygen logs must be maintained by the provider. The time between any reading shall not exceed more than 45 days. The documentation maintained in the provider record must contain the following:

- The initial, periodic and ending reading on the time meter clock on each oxygen system, and
- The dates of each initial, periodic and ending reading, and
- Evidence of ongoing need for oxygen services.

4. The maximum Medicaid payment will be based on the least costly method of oxygen delivery.

5. Oxygen prescribed "PRN" or "as necessary" is not payable.

6. Medicaid payment will be made for the rental of equipment only. All accessories and disposable supplies related to the oxygen delivery system and costs for servicing and repair of equipment are included in the Medicaid payment and shall not be separately payable.

7. Payment is not allowed for oxygen services that are not documented according to the department of inspections, appeals, and licensing requirements in 481—Chapter 58.

(2) Speech generating devices with approved medical necessity.

(3) Wheelchairs for members in an ICF/ID.

b. The types of DME covered through the Medicaid program include but are not limited to:

Automated medication dispenser.

Bathtub/shower chair, bench. See subrule 78.10(5) for prior authorization requirements.

Commode, shower commode chair. See subrule 78.10(5) for prior authorization requirements.

Decubitus equipment.

Dialysis equipment.

Diaphragm (contraceptive device).

Enclosed bed. See subrule 78.10(5) for prior authorization requirements.

Enuresis alarm system (bed-wetting alarm device) for members five years of age or older.

Heat/cold application device.

Hospital bed and accessories.

Inhalation equipment. See subrule 78.10(5) for prior authorization requirements.

Insulin infusion pump. See subrule 78.10(5) for prior authorization requirements.

Lymphedema pump.

Mobility device and accessories. See subrule 78.10(5) for prior authorization requirements.

Neuromuscular stimulator.

Oximeter.

Oxygen, subject to the limitations in paragraphs 78.10(2) “a” and “c.”

Patient lift. See subrule 78.10(5) for prior authorization requirements.

Phototherapy bilirubin light.

Protective helmet.

Seat lift chair.

Speech generating device. See subrule 78.10(5) for prior authorization requirements.

Traction equipment.

Ventilator.

c. Coverage of home oxygen equipment and oxygen will be considered reasonable and necessary for members in accordance with Medicare criteria and as shown by supporting medical documentation. The physician, PA, or ARNP shall document that other forms of treatment are contraindicated or have been tried and have not been successful and that oxygen therapy is required. EXCEPTION: Home oxygen equipment and oxygen are covered for children through three years of age when prescribed by a physician, PA, or ARNP. A pulse oximeter reading must be obtained yearly and documented in the provider and physician record.

(1) To identify the medical necessity for oxygen therapy, medical documentation, or a reasonable facsimile completed by a physician, PA, or ARNP shall qualify the member in accordance with Medicare criteria.

(2) If the member’s condition or need for oxygen services changes, the attending physician, PA, or ARNP must adjust the documentation accordingly.

(3) A second oxygen system is not covered by Medicaid when used as a backup for oxygen concentrators or as a standby in case of emergency. Members may be provided with a portable oxygen system to complement a stationary oxygen system, or to be used by itself, with documentation from the physician, PA, or ARNP of the specific activities for which portable oxygen is medically necessary.

(4) Payment for oxygen systems will be made only on a rental basis for the duration of use.

(5) All accessories, disposable supplies, servicing, and repairing of oxygen systems are included in the monthly Medicaid payment for oxygen systems.

(6) Oxygen prescribed “PRN” or “as necessary” is not allowed.

d. Wheelchairs, wheelchair accessories, and wheelchair modifications are covered when they are medically necessary for mobility within the home, nursing facility, or intermediate care facility. Wheelchairs are defined as:

(1) Standard manual wheelchairs. Coverage of a standard manual wheelchair includes the following:

1. Complete set of tires/wheels and casters, any type;
2. Hand rims with or without projections;
3. Weight-specific components required by the patient-weight capacity of the wheelchair;
4. Elevating legrest, lower extension tube and upper hanger bracket;
5. Armrest (detachable, non-adjustable or adjustable) with or without arm pad;
6. Footrest (swingaway, detachable), including lower extension tube(s) and upper hanger bracket;
7. Standard size footplates;
8. Wheelchair bearings;

9. Caster fork, replacement only; and
10. All labor charges involved in the assembly of the wheelchair (including but not limited to front caster assembly, rear wheel assembly, ratchet assembly, wheel lock assembly, footrest assembly).

(2) Standard manual wheelchair accessories that are separately billable and require prior authorization include the following:

1. Headrest extensions;
2. One-arm drive attachments;
3. Positioning accessories;
4. Specialized skin protection seat and back cushions; and
5. Anti-rollback devices.

(3) Standard power wheelchair. Coverage of a standard power wheelchair requires prior authorization and includes the following:

1. Lap belt or safety belt;
2. Battery charger, single mode;
3. Complete set of tires/wheels and casters, any type;
4. Legrests (fixed, swingaway, or detachable non-elevation legrests with or without calf pad);
5. Footrests/foot platform (fixed, swingaway, detachable footrests or a foot platform without angle adjustment, single adjustable footplate);
6. Armrests (fixed, swingaway, detachable non-adjustable height armrests with arm pad provided);

7. Any weight-specific components (braces, bars, upholstery, brackets, motors, gears, etc.) as required by patient-weight capacity of the wheelchair;

8. Any seat width and depth. For power wheelchairs with a sling/solid seat/back, the following may be billed separately:

- For standard duty, seat width and/or depth greater than 20 inches;
- For heavy duty, seat width and/or depth greater than 22 inches;
- For very heavy duty, seat width and/or depth greater than 24 inches;
- EXCEPTION: For extra heavy duty, there is no separate billing;

9. Any back width. For power wheelchairs with a sling/solid seat/back, the following may be billed separately:

- For standard duty, seat width and/or depth greater than 20 inches;
- For heavy duty, seat width and/or depth greater than 22 inches;
- For very heavy duty, seat width and/or depth greater than 24 inches;
- EXCEPTION: For extra heavy duty, there is no separate billing;

10. Non-expandable controller or standard proportional joystick (integrated or remote); and

11. All labor charges involved in the assembly of the wheelchair (including but not limited to front caster assembly, rear wheel assembly, ratchet assembly, wheel lock assembly, footrest assembly).

(4) Standard power wheelchair accessories that are billed separately and require a prior authorization include the following:

1. Shoulder harness/straps or chest straps/vest;
2. Elevating legrest;
3. Angle adjustable footplates;
4. Adjustable height armrests; and
5. Expandable controller or nonstandard joystick (i.e., non-proportional or mini, compact or short throw proportional, or other alternative control device).

(5) Customized items are payable with a prior authorization, in accordance with 42 CFR 414.224 as amended to July 1, 2026.

78.10(3) Prosthetic devices. Prosthetic devices mean replacement, corrective, or supportive devices prescribed by a physician (doctor of medicine, osteopathy or podiatry), PA, or ARNP within the scope of practice as defined by state law to artificially replace a missing portion of the body, prevent or correct a physical deformity or malfunction, or support a weak or deformed portion of the

body. This does not require a determination that there is no possibility that the member's condition may improve sometime in the future.

a. Prosthetic devices are not covered when dispensed to a member prior to the time the member undergoes a procedure which will make necessary the use of the device.

b. The types of prosthetic devices covered through the Medicaid program include but are not limited to:

- (1) Artificial eyes.
- (2) Artificial limbs.
- (3) Enteral delivery supplies and products. See subrule 78.10(5) for prior authorization requirements.
- (4) Hearing aids. See rule 441—78.14(249A).
- (5) Orthotic devices. See paragraph 78.10(3)“c” for limitations on coverage of cranial orthotic devices.
- (6) Ostomy appliances.
- (7) Parenteral delivery supplies and products. Daily parenteral nutrition therapy is considered necessary and reasonable for a member with severe pathology of the alimentary tract that does not allow absorption of sufficient nutrients to maintain weight and strength commensurate with the member's general condition.
- (8) Prosthetic shoes, orthopedic shoes. See rule 441—78.15(249A).
- (9) Tracheotomy tubes.
- (10) Vibrotactile aids. Vibrotactile aids are payable only once in a four-year period unless the original aid is broken beyond repair or lost.

c. Cranial orthotic device. Payment will be approved for cranial orthotic devices when the device is medically necessary for the postsurgical treatment of synostotic plagiocephaly. Payment shall also be approved when there is documentation supporting moderate to severe nonsynostotic positional plagiocephaly and meets minimum medical necessity requirements.

78.10(4) Medical supplies. Medical supplies are nondurable items consumed in the process of giving medical care, for example, nebulizers, gauze, bandages, sterile pads, adhesive tape, and sterile absorbent cotton. Medical supplies are payable for a specific medicinal purpose. This does not include food or drugs. However, active pharmaceutical ingredients and excipients that are identified as preferred on the preferred drug list published by the department pursuant to Iowa Code section 249A.20A are covered. Medical supplies shall not be dispensed at any one time in quantities exceeding a 31-day supply for active pharmaceutical ingredients and excipients or a three-month supply for all other items. After the initial dispensing of medical supplies, the provider must document a refill request from the Medicaid member or the member's caregiver for each refill.

a. The types of medical supplies and supplies necessary for the effective use of a payable item covered through the Medicaid program include but are not limited to:

Active pharmaceutical ingredients and excipients identified as preferred on the preferred drug list published pursuant to Iowa Code section 249A.20A.

Catheter (indwelling Foley).

Colostomy and ileostomy appliances.

Colostomy and ileostomy care dressings, liquid adhesive, and adhesive tape.

Diabetic supplies (including but not limited to blood glucose test strips, lancing devices, lancets, needles, syringes, and diabetic urine test supplies). See subrule 78.10(5) for prior authorization requirements.

Dialysis supplies.

Disposable catheterization trays or sets (sterile).

Disposable irrigation trays or sets (sterile).

Disposable saline enemas (e.g., sodium phosphate type).

Dressings.

Elastic antiembolism support stocking.

Enema.

Hearing aid batteries.

Incontinence products (for members three years of age and older).

Oral nutritional products. See subrule 78.10(5) for prior authorization requirements.

Ostomy appliances and supplies.

Respirator supplies.

Shoes, diabetic.

Surgical supplies.

Urinary collection supplies.

b. Only the following types of medical supplies will be approved for payment for members receiving care in a nursing facility or an ICF/ID when prescribed by the physician, PA, or ARNP:

(1) Catheter (indwelling Foley).

(2) Diabetic supplies (including but not limited to lancing devices, lancets, needles and syringes, blood glucose test strips, and diabetic urine test supplies).

(3) Disposable catheterization trays or sets (sterile).

(4) Disposable irrigation trays or sets (sterile).

(5) Disposable saline enemas (e.g., sodium phosphate type).

(6) Ostomy appliances and supplies.

(7) Shoes, diabetic.

78.10(5) Prior authorization requirements. Prior authorization pursuant to rule 441—79.8(249A) is required for some medical equipment and supplies. Refer to the department's website for a list of items that require a prior authorization.

[ARC 0315D, IAB 5/27/26, effective 7/1/26]

441—78.11(249A) Ambulance service. Payment will be approved for ambulance service if it is required by the recipient's condition and the recipient is transported to the nearest hospital with appropriate facilities or to one in the same locality, from one hospital to another, to the patient's home, to a nursing facility, or to a mental health access center. Payment for ambulance service to the nearest hospital for outpatient service will be approved only for emergency treatment. Ambulance service must be medically necessary and not merely for the convenience of the patient.

78.11(1) Partial payment may be made when an individual is transported beyond the destinations specified, and is limited to the amount that would have been paid had the individual been transported to the nearest institution with appropriate facilities. When transportation is to the patient's home, partial payment is limited to the amount that would have been paid from the nearest institution with appropriate facilities. When a recipient who is a resident of a nursing care facility is hospitalized and later discharged from the hospital, payment will be made for the trip to the nursing care facility where the recipient resides even though it may not in fact be the nearest nursing care facility.

78.11(2) Iowa Medicaid will determine that the ambulance transportation was medically necessary and that the condition of the patient precluded any other method of transportation. Payment can be made without the physician's confirmation when:

a. The individual is admitted as a hospital inpatient or is in an emergency situation.

b. Previous information on file relating to the patient's condition clearly indicates ambulance service was necessary.

78.11(3) When a patient is transferred from one nursing home to another because of the closing of a facility or from a nursing home to a custodial home because the recipient no longer requires nursing care, the conditions of medical necessity and the distance requirements will not be applicable. Approval for transfer will be made by the department prior to the transfer. When such a transfer is made, the following rate schedule will apply:

One patient - normal allowance

Two patients - 3/4 normal allowance per patient

Three patients - 2/3 normal allowance per patient

Four patients - 5/8 normal allowance per patient

78.11(4) Transportation of hospital inpatients. When an ambulance service provides transport of a hospital inpatient to a provider and returns the recipient to the same hospital (the recipient continuing to be an inpatient of the hospital), the ambulance service shall bill the hospital for reimbursement as the hospital's DRG reimbursement system includes all costs associated with providing inpatient services as stated in 441—paragraph 79.1(5) “j.”

78.11(5) In the event that more than one ambulance service is called to provide ground ambulance transport, payment will be made only to one ambulance company. When a paramedic from one ambulance service joins a ground ambulance company already in transport, coverage is not available for the services and supplies provided by the paramedic.

[ARC 0315D, IAB 5/27/26, effective 7/1/26]

441—78.12(249A) Behavioral health intervention. Payment will be made for behavioral health intervention services not otherwise covered under this chapter that are designed to minimize or, if possible, eliminate the symptoms or causes of a mental disorder, subject to the limitations in this rule.

78.12(1) Definitions.

“*Behavioral health intervention*” means skill-building services that focus on:

1. Addressing the mental and functional disabilities that negatively affect a member's integration and stability in the community and quality of life;
2. Improving a member's health and well-being related to the member's mental disorder by reducing or managing the symptoms or behaviors that prevent the member from functioning at the member's best possible functional level; and
3. Promoting a member's mental health recovery and resilience through increasing the member's ability to manage symptoms.

“*Licensed practitioner of the healing arts*” or “*LPHA*,” as used in this rule, means a practitioner such as a physician (M.D. or D.O.), a PA, an ARNP, a psychologist, a social worker (LMSW or LISW), a marital and family therapist (LMFT), or a mental health counselor (LMHC) who is licensed by the applicable state authority for that profession.

“*Managed care organization*” means an entity that (1) is under contract with the department to provide services to Medicaid recipients and (2) meets the definition of “health maintenance organization” as defined in Iowa Code section 514B.1.

“*Mental disorder*” means a disorder, dysfunction, or dysphoria diagnosed pursuant to the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association as amended to July 1, 2026, excluding intellectual disabilities, personality disorders, medication-induced movement disorders and other adverse effects of medication, and other conditions that may be a focus of clinical attention.

78.12(2) Covered services.

a. Service setting.

(1) Community-based behavioral health intervention is available to a member living in a community-based environment. Services have a primary goal of assisting the member and the member's family to learn age-appropriate skills to manage behavior and regain or retain self-control. Depending on the member's age and diagnosis, specific services offered may include:

1. Behavior intervention,
2. Crisis intervention,
3. Skill training and development, and
4. Family training.

(2) Residential behavioral health intervention is available to members eligible for foster group care payment pursuant to 441—subrule 156.20(1). Services have the primary goal of assisting the member to prepare to transition to the community through learning age-appropriate skills to manage behavior and regain or retain self-control. Specific services offered include:

1. Behavior intervention,

2. Crisis intervention, and
3. Family training.
- (3) Behavioral health intervention is not covered for members who are in an acute care or psychiatric hospital, a long-term care facility, or a psychiatric medical institution for children.
 - b. Crisis intervention.* Crisis intervention services shall provide a focused intervention and rapid stabilization of acute symptoms of mental illness or emotional distress. The intervention shall be designed to de-escalate situations in which a risk to self, others, or property exists.
 - (1) Services shall assist a member to regain self-control and reestablish effective management of behavioral symptoms associated with a psychological disorder in an age-appropriate manner.
 - (2) Crisis intervention is covered only for Medicaid members who are aged 20 or under and shall be provided as outlined in a written treatment plan.
 - (3) Crisis intervention services do not include control room or other restraint activities.
 - c. Behavior intervention.* Behavior intervention includes services designed to modify the psychological, behavioral, emotional, cognitive, and social factors affecting a member's functioning.
 - (1) Interventions may address the following skills for effective functioning with family, peers, and community in an age-appropriate manner:
 1. Cognitive flexibility skills,
 2. Communication skills,
 3. Conflict resolution skills,
 4. Emotional regulation skills,
 5. Executive skills,
 6. Interpersonal relationship skills,
 7. Problem-solving skills, and
 8. Social skills.
 - (2) Behavior intervention shall be provided in a location appropriate for skill identification, teaching and development. Intervention may be provided in an individual, family, or group format as appropriate to meet the member's needs.
 - (3) Behavior intervention is covered only for Medicaid members aged 20 or under.
 - (4) Covered services include only direct teaching or development of skills and not general recreation, non-skill-based activities, mentoring, or interruption of school.
 - d. Family training.* Family training is covered only for Medicaid members aged 20 or under.
 - (1) Family training services shall:
 1. Enhance the family's ability to effectively interact with the child and support the child's functioning in the home and community, and
 2. Teach parents to identify and implement strategies to reduce target behaviors and reinforce the appropriate skills.
 - (2) Training provided must:
 1. Be for the direct benefit of the member, and
 2. Be based on a curriculum with a training manual.
 - e. Skill training and development.* Skill training and development services are covered for Medicaid members aged 18 or over.
 - (1) Skill training and development shall consist of interventions to:
 1. Enhance a member's independent living, social, and communication skills;
 2. Minimize or eliminate psychological barriers to a member's ability to effectively manage symptoms associated with a psychological disorder; and
 3. Maximize a member's ability to live and participate in the community.
 - (2) Interventions may include training in the following skills for effective functioning with family, peers, and community:
 1. Communication skills,
 2. Conflict resolution skills,
 3. Daily living skills,

4. Employment-related skills,
5. Interpersonal relationship skills,
6. Problem-solving skills, and
7. Social skills.

78.12(3) *Excluded services.*

a. Services that are habilitative in nature are not covered as behavioral health interventions. For purposes of this subrule, “habilitative services” means services that are designed to assist individuals in acquiring skills that they never had, as well as associated training to acquire self-help, socialization, and adaptive skills necessary to reside successfully in a home or community setting.

b. Respite, day care, education, and recreation services are not covered as behavioral health interventions.

78.12(4) *Coverage requirements.* Medicaid covers behavioral health intervention only when the following conditions are met:

a. A licensed practitioner of the healing arts acting within the practitioner’s scope of practice under state law has diagnosed the member with a psychological disorder.

b. The licensed practitioner of the healing arts has recommended the behavioral health intervention as part of a plan of treatment designed to treat the member’s psychological disorder. The plan of treatment shall be comprehensive in nature and shall detail all behavioral health services that the member may require, not only services included under behavioral health intervention.

(1) The member’s need for services must meet specific individual goals that are focused to address:

1. Risk of harm to self or others,
2. Behavioral support in the community,
3. Specific skills impaired due to the member’s mental illness, and
4. Needs of children at risk of out-of-home placement due to mental health needs or the transition back to the community or home following an out-of-home placement.

(2) Diagnosis and treatment plan development are covered services.

c. For a member under the age of 21, the licensed practitioner of the healing arts:

(1) Has, in cooperation with the managed care contractor, selected a standardized assessment instrument appropriate for baseline measurement of the member’s current skill level in managing mental health needs;

(2) Has completed an initial formal assessment of the member using the instrument selected; and

(3) Completes a formal assessment every six months thereafter if continued services are ordered.

d. The behavioral health intervention provider has prepared a written services implementation plan that meets the requirements of subrule 78.12(5).

78.12(5) *Approval of plan.* The behavioral health intervention provider shall contact the member’s managed care plan for authorization of the services.

a. *Initial plan.* The initial services implementation plan must meet all of the following criteria:

(1) The plan conforms to the medical necessity requirements in subrule 78.12(6);

(2) The plan is consistent with the written diagnosis and treatment recommendations made by the licensed practitioner of the healing arts;

(3) The plan is sufficient in amount, duration, and scope to reasonably achieve its purpose;

(4) The provider meets the requirements of rule 441—77.13(249A); and

(5) The plan does not exceed six months’ duration.

b. *Subsequent plans.* The member’s managed care plan may approve a subsequent services implementation plan according to the conditions in paragraph 78.12(5)“a” if the services are recommended by a licensed practitioner of the healing arts who has:

(1) Reexamined the member;

(2) Reviewed the original diagnosis and treatment plan; and

(3) Evaluated the member’s progress, including a formal assessment as required by subparagraph 78.12(4)“c”(3).

78.12(6) *Medical necessity.* Nothing in this rule shall be deemed to exempt coverage of behavioral health intervention from the requirement that services be medically necessary. For purposes of behavioral health intervention, “medically necessary” means that the service is:

- a.* Consistent with the diagnosis and treatment of the member’s condition and specific to a daily impairment caused by a mental disorder;
- b.* Required to meet the medical needs of the member and is needed for reasons other than the convenience of the member or the member’s caregiver;
- c.* The least costly type of service that can reasonably meet the medical needs of the member; and
- d.* In accordance with the standards of evidence-based medical practice. The standards of practice for each field of medical and remedial care covered by the Iowa Medicaid program are those standards of practice identified by:
 - (1) Knowledgeable Iowa clinicians practicing or teaching in the field; and
 - (2) The professional literature regarding evidence-based practices in the field.

[ARC 0315D, IAB 5/27/26, effective 7/1/26]

441—78.13(249A) Nonemergency medical transportation. The department makes available nonemergency medical transportation through a transportation brokerage. Medicaid members who are eligible for full Medicaid benefits and need transportation services so they can receive Medicaid-covered services from providers enrolled with the Iowa Medicaid program may obtain transportation services consistent with this rule.

78.13(1) *Covered services.* Nonemergency medical transportation services available are limited to:

a. The most economical transportation appropriate to the needs of the member, provided to members eligible for nonemergency transportation when those members need transportation to providers enrolled in the Iowa Medicaid program for the receipt of goods or services covered by the Iowa Medicaid program. Consistent with the member’s needs and subject to the limitations and restrictions set forth in this rule, subject to the advance approval of the broker, such transportation may include:

- (1) Mileage reimbursement to the member, if the member is the driver.
- (2) Mileage reimbursement to a volunteer or other responsible person, if the volunteer or other responsible person is the driver.
- (3) Taxi service.
- (4) Public transportation when public transportation is reasonably available and the member’s condition does not preclude its use.
- (5) Wheelchair and stretcher vans.
- (6) Airfare costs when the most appropriate mode of transport is by air, based on the member’s medical condition.

b. Reimbursement for costs of the member’s meals necessary during periods of transportation and medical treatment.

c. Reimbursement of lodging expenses incurred by the member during periods of transportation and medical treatment.

d. Reimbursement of car rental costs incurred by the member during periods of transportation and medical treatment.

e. Reimbursement of a medically necessary escort’s travel expenses when an escort is required because of the member’s needs.

78.13(2) *Exclusions.* Nonemergency medical transportation is not available through the Iowa Medicaid program for:

- a.* Transportation to obtain services not covered by Iowa Medicaid;
- b.* Transportation to providers that are not enrolled in Iowa Medicaid;

- c. Transportation for members residing in nursing facilities or ICF/ID facilities when such facilities provide the transportation (i.e., within 30 miles, one way, of the facility);
- d. Transportation of family members to visit or participate in therapy when the member is hospitalized or institutionalized;
- e. Transportation to DME providers when such providers offer a delivery service that can be accessed at no cost to the member, unless the equipment requires a fitting that cannot be provided without transporting the member;
- f. Reimbursement to HCBS and Medicaid providers for transportation provided as part of other covered services, such as personal care, home health, and supported community living services;
- g. Transportation to a pharmacy that provides a free delivery service, with the exception of new prescription fills that are otherwise not available to the patient in the absence of nonemergency medical transportation services; and
- h. Emergency transportation.

78.13(3) *Conditions and limitations on covered services.* Nonemergency medical transportation services are subject to the following limitations and conditions:

a. *Member request.* When a member needs nonemergency transportation to receive medical care provided by the Iowa Medicaid program, the member must contact the broker with as much advance notice as possible, but not more than 30 days' advance notice.

(1) Generally, members who require a ride from a transportation provider scheduled by the broker must contact the broker at least two business days in advance of the member's appointment to schedule the transportation. For purposes of calculating the two-business-day notice obligation, the advance notice includes the day of the medical appointment but not the day of the telephone call.

(2) If the member's nonemergency transportation need for a ride from a transportation provider scheduled by the broker makes the provision of two business days' notice impossible because of the member's urgent transportation need, the member must provide as much advance notice as is possible before the transportation need so that the broker can appropriately schedule the most economical form of transportation for the member. Urgent transportation needs for a ride from a transportation provider scheduled by the broker are limited to unscheduled episodic situations in which there is no immediate threat to life or limb but which require that the broker schedule transportation with less than two business days' notice. Examples of urgent trips include but are not limited to:

- 1. Postsurgical or medical follow-up care specified by a health care provider;
- 2. Unexpected preoperative appointments;
- 3. Hospital discharges;
- 4. Appointments for new medical conditions or tests; and
- 5. Dialysis.

(3) The two-business-day advance notice obligation does not apply when the member requests only mileage reimbursement. To be eligible for mileage reimbursement:

- 1. The member must notify the broker no later than the day of the trip;
- 2. The transportation must be provided by a driver with a valid driver's license and insurance coverage on the vehicle at the time of the transport; and
- 3. The other requirements of rule 441—78.13(249A) must be met.

b. *No free transportation alternatives available.* Member transportation through the nonemergency medical transportation broker is not available to the member when the member is capable of securing the member's own transportation at no cost to the member (e.g., free-gas voucher programs).

c. *No member transportation alternatives available.* Members who have their own transportation available to them are required to use their own vehicle and seek mileage reimbursement. For purposes of determining whether or not the member has the member's own transportation that is available to the member, the broker shall take into consideration:

- (1) Whether the member owns a vehicle;
- (2) Whether a member-owned vehicle is in working mechanical order and is licensed;

- (3) Whether the member has a valid driver's license and auto insurance;
- (4) Whether the member is unable to drive because of age, physical condition, cognitive impairment, or developmental limitations; and
- (5) Whether friends or family are available to transport the member to the member's medical appointment and receive mileage reimbursement.

d. Limitations on reimbursement for meals. Reimbursement for costs of members' meals necessary during periods of transportation and medical treatment is limited to situations in which:

- (1) The transportation being provided spans the entire meal period;
- (2) The one-way distance to or from the medical appointment is more than 50 miles;
- (3) The meal is necessary to satisfy the needs of the member or medically necessary escort; and
- (4) The meal reimbursement is limited to the subsistence allowance amounts applicable to state officers and state employees pursuant to rule 11—41.6(8A) and is supported by detailed receipts.

e. Limitations on reimbursement for lodging expenses. Reimbursement of lodging expenses incurred by members during periods of transportation and medical treatment is limited to reasonable reimbursement for expenses incurred by the member or the medically necessary escort, or both, during a nonemergency trip provided by the broker when the one-way distance to or from the medical appointment is more than 50 miles, supported by detailed receipts, and required for treatment.

f. Closest medical provider. Nonemergency medical transportation will only be provided to members to the closest qualified and enrolled Medicaid provider unless:

- (1) The difference between the closest qualified and enrolled Medicaid provider and the enrolled provider requested by the member is less than 10 miles one way; or
- (2) The additional cost of transportation to the enrolled provider requested by the member is medically justified based on:

1. The member's previous relationship with the requested provider; or
2. The member's prior experience with the requested provider; or
3. The requested provider's special expertise or experience; or
4. A referral requiring the member to be seen by the requested provider.

g. Member scheduling obligations. Members who require a ride will need to schedule medical appointments on days the transportation provider sends a shuttle to facilitate the provision of the most economical nonemergency medical transportation available, subject to reasonable medical exceptions.

h. Abusive behavior. Members who are abusive or inappropriate may be restricted by the department to only receiving mileage reimbursement. Such restricted members will be responsible for finding their own way to their medical appointments.

i. Member claim submission. Members must submit claims and supporting documentation to the broker within 120 days of the date of service. The broker shall deny member claims submitted more than 120 days from the date of service.

78.13(4) Grievance procedure. The broker shall establish an internal grievance procedure for members and transportation providers.

a. Members may appeal to the department pursuant to 441—Chapter 2506 as an "aggrieved person."

b. Transportation providers.

- (1) Consent for state fair hearing.

1. Transportation providers that are contracted with the broker and are in good standing with the broker may request a state fair hearing only for disputes regarding payment of claims, specifically, disputes concerning the denial of a claim or reduction in payment, and only when acting on behalf of the member.

2. The transportation provider requesting such a state fair hearing must have the prior, express, signed written consent of the member or the member's lawfully appointed guardian in order to request such a hearing. Notwithstanding any contrary provision in 441—Chapter 2506, no state fair hearing will be granted unless the transportation provider submits a document providing such member approval with the request for a state fair hearing.

3. The document must specifically inform the member that protected health information (PHI) may be discussed at the hearing and may be made public in the course of the hearing and subsequent administrative and judicial proceedings. The document must contain language that indicates the knowledge of the potential for PHI to become public and that the member knowingly, voluntarily and intelligently consents to the network provider's bringing the state fair hearing on the member's behalf.

(2) For all transportation provider grievances not addressed by paragraph 78.13(4)"b," the grievance process shall end with binding arbitration, with a designee of Iowa Medicaid as arbitrator.

[ARC 0315D, IAB 5/27/26, effective 7/1/26]

441—78.14(249A) Hearing aids. Payment will be approved for a hearing aid and examinations subject to the following conditions:

78.14(1) Physician examination. The member shall have an examination by a physician to determine that the member has no condition that would contraindicate the use of a hearing aid. This report shall be documented in the patient record. The requirement for a physician evaluation shall be waived for members 18 years of age or older when the member has signed an informed consent statement acknowledging that the member:

a. Has been advised that it may be in the member's best health interest to receive a medical evaluation from a licensed physician before purchase of a hearing aid.

b. Does not wish to receive a medical evaluation prior to purchase of a hearing aid.

78.14(2) Audiological testings. A physician or an audiologist shall perform audiological testing as a part of making a determination that a member could benefit from the use of a hearing aid. The department will cover vestibular testing performed by an audiologist only when prescribed by a physician.

78.14(3) Hearing aid evaluation. A physician or an audiologist shall perform a hearing aid evaluation to establish if a member could benefit from a hearing aid. When a hearing aid is recommended for a member, the physician or audiologist recommending the hearing aid shall see the member at least one time within 30 days after purchase of the hearing aid to determine that the aid is adequate.

78.14(4) Hearing aid selection. A physician or audiologist may recommend a specific brand or model appropriate to the member's condition. When a physician or an audiologist makes a general hearing aid recommendation, a hearing aid dispenser may perform the tests to determine the specific brand or model appropriate to the member's condition.

78.14(5) Travel. When a member is unable to travel to the physician or audiologist because of health reasons, the department will make payment for travel to the member's place of residence or other suitable location. The department will make payment to physicians as specified in 78.1(8) and payment to audiologists at the same rate it reimburses state employees for travel.

78.14(6) Purchase of hearing aid. The department will pay for the type of hearing aid recommended when purchased from an eligible licensed hearing aid dispenser pursuant to rule 441—77.14(249A). The department will pay for binaural amplification when:

- a. A child needs the aid for speech development,
- b. The aid is needed for educational or vocational purposes,
- c. The aid is for a blind member,
- d. The member's hearing loss has caused marked restriction of daily activities and constriction of interests resulting in seriously impaired ability to relate to other people, or
- e. Lack of binaural amplification poses a hazard to a member's safety.

78.14(7) Payment for hearing aids.

a. Payment for hearing aids will be acquisition cost plus a dispensing fee covering the fitting and service for six months. The department will make payment for routine service after the first six months. Dispensing fees and payment for routine service shall not exceed the fee schedule appropriate to the place of service. Shipping and handling charges are not allowed.

b. Payment for ear mold and batteries will be at the current audiologist's fee schedule.

c. Payment for repairs will be made to the dealer for repairs made by the dealer. Payment for in-house repairs will be made at the current fee schedule. Payment will also be made to the dealer for repairs when the hearing aid is repaired by the manufacturer or manufacturer's depot. Payment for out-of-house repairs will be at the amount shown on the manufacturer's invoice. Payment will be allowed for a service or handling charge when it is necessary for repairs to be performed by the manufacturer or manufacturer's depot and this charge is made to the general public.

d. Prior approval. When prior approval is required, an Examiner Report of Need for a Hearing Aid form shall be submitted along with the forms required by 441—paragraph 79.8(1) "a."

(1) Payment for the replacement of a hearing aid less than four years old will require prior approval except when the member is under 21 years of age. The department will approve payment when the original hearing aid is lost or broken beyond repair or there is a significant change in the member's hearing that would require a different hearing aid.

(2) Payment for a hearing aid costing more than \$650 will require prior approval. The department will approve payment for either of the following purposes:

1. Educational purposes when the member is participating in primary or secondary education or in a postsecondary academic program leading to a degree and an in-office comparison of an analog aid and a digital aid matched (+/- 5dB) for gain and output shows a significant improvement in either speech recognition in quiet or speech recognition in noise or an in-office comparison of two aids, one of which is single channel, shows significantly improved audibility.

2. Vocational purposes when documentation submitted indicates the necessity, such as varying amounts of background noise in the work environment and a need to converse in order to do the job, and an in-office comparison of an analog aid and a digital aid matched (+/- 5dB) for gain and output shows a significant improvement in either speech recognition in quiet or speech recognition in noise or an in-office comparison of two aids, one of which is single channel, shows significantly improved audibility.

[ARC 0315D, IAB 5/27/26, effective 7/1/26]

441—78.15(249A) Orthopedic shoes. Payment will be approved only for depth or custom-molded orthopedic shoes, inserts, and modifications, subject to the following definitions and conditions.

78.15(1) Definitions.

"Custom-molded shoe" means a shoe that:

1. Has been constructed over a cast or model of the recipient's foot;
2. Is made of leather or another suitable material of equal quality;
3. Has inserts that can be removed, altered, or replaced according to the recipient's conditions and needs; and
4. Has some form of closure.

"Depth shoe" means a shoe that:

1. Has a full length, heel-to-toe filler that when removed provides a minimum of 3/16 inch of additional depth used to accommodate custom-molded or customized inserts;
2. Is made from leather or another suitable material of equal quality;
3. Has some form of closure; and
4. Is available in full and half sizes with a minimum of three widths, so that the sole is graded to the size and width of the upper portions of the shoe according to the American Standard last sizing schedule as amended to July 1, 2026, or its equivalent.

"Insert" means a foot mold or orthosis constructed of more than one layer of a material that:

1. Is soft enough and firm enough to take and hold an impression during use, and
2. Is molded to the recipient's foot or is made over a model of the foot.

78.15(2) Prescription. The recipient shall present to the provider a written prescription by a physician, a podiatrist, a PA, or an ARNP that includes all of the following:

- a. The date.
- b. The patient's diagnosis.

- c. The reason orthopedic shoes are needed.
- d. The probable duration of need.
- e. A specific description of any required modification of the shoes.

78.15(3) *Diagnosis.* The recipient shall have a diagnosis of an orthopedic, neuromuscular, vascular, or insensate foot condition, supported by applicable codes from the International Classification of Diseases (ICD) as amended to July 1, 2026. A diagnosis of flat feet is not covered.

a. A recipient with diabetes must meet the Medicare criteria for therapeutic depth and custom-molded shoes.

b. Custom-molded shoes are covered only when the recipient has a foot deformity and the provider has documentation of all of the following:

- (1) The reasons the recipient cannot be fitted with a depth shoe.
- (2) Pain.
- (3) Tissue breakdown or a high probability of tissue breakdown.
- (4) Any limitation on walking.

78.15(4) *Frequency.* Only two pairs of orthopedic shoes are allowed per recipient in a 12-month period unless documentation of change in size or evidence of excessive wear is submitted. **EXCEPTION:** School-aged children under the age of 21 may obtain athletic shoes in addition to the two pairs of shoes in a 12-month period.

[ARC 0315D, IAB 5/27/26, effective 7/1/26]

441—78.16(249A) Community mental health centers. Payment will be approved for all reasonable and necessary services provided by a psychiatrist on the staff of a community mental health center. Payment will be approved for services provided by a clinical psychologist, social worker or psychiatric nurse on the staff of the center, subject to the following conditions:

78.16(1) Payment to a community mental health center will be approved for reasonable and necessary services provided to members by a psychiatrist, psychologist, social worker or psychiatric nurse on the staff of the center under the following conditions:

a. Services must be rendered under the supervision of a board-eligible or board-certified psychiatrist. All services must be performed under the supervision of a board-eligible or board-certified psychiatrist subject to the conditions set forth in 78.16(1) “b” with the following exceptions:

- (1) Services by staff psychiatrists, or
- (2) Services rendered by psychologists meeting the requirements of the National Register of Health Service Providers in Psychology as amended to July 1, 2026, or
- (3) Services provided by a staff member listed in this subrule performing the preliminary diagnostic evaluation of a member for voluntary admission to one of the state mental health institutes.

b. Supervisory process.

(1) Each patient shall have an initial evaluation completed that shall include at least one personal evaluation interview with a mental health professional, as defined under Iowa Code section 228.1. If the evaluation interview results indicate a need for an interview with a board-eligible or board-certified psychiatrist, then such referral shall be made. This must be accomplished before submission of the first claim for services rendered to that patient.

(2) Ongoing review and assessment of patients’ treatment needs, treatment plans, and the appropriateness of services rendered shall be assured through the peer review process in effect for community mental health centers, as directed by 2002 Iowa Acts, chapter 1120, section 13.

78.16(2) The treatment plans for and services rendered to patients of the center shall be evaluated and revised as necessary and appropriate, consistent with the standards of the peer review process described in subparagraph 78.16(1) “b”(1).

78.16(3) The peer review process and related activities, as described under subparagraph 78.16(1) “b”(1), are not payable as separate services under the Medicaid program. The center shall maintain the results of and information related to the peer review process, and these records shall be subject to audit by the department or its designees, as necessary and appropriate.

78.16(4) Clinical records of medical assistance patients shall be available to the carrier on request. All these records shall be held confidential.

78.16(5) At the time of application for participation in the program the center will be provided with a form on which to list its professional staff. The center shall report acquisitions or losses of professional staff to the carrier within ten days.

78.16(6) Payment to a community mental health center will be approved for day treatment services for persons aged 21 or over if the center is certified by the department for day treatment services, the services are provided on the premises of the community mental health center or satellite office of the community mental health center, and the services meet the standards outlined herein.

a. Community mental health centers providing day treatment services for persons aged 21 or over shall have available a written narrative providing the following day treatment information:

(1) Documented need for day treatment services for persons aged 21 and over in the area served by the program, including studies, needs assessments, and consultations with other health care professionals.

(2) Goals and objectives of the day treatment program for persons aged 21 and over that meet the day treatment program guidelines noted in 78.16(6) “*b.*”

(3) Organization and staffing including how the day treatment program for persons aged 21 and over fits with the rest of the community mental health center, the number of staff, staff credentials, and the staff’s relationship to the program, e.g., employee, contractual, or consultant.

(4) Policies and procedures for the program including admission criteria, patient assessment, treatment plan, discharge plan, postdischarge services, and the scope of services provided.

(5) Any accreditations or other types of approvals from national or state organizations.

(6) The physical facility and any equipment to be utilized.

b. Day treatment services for persons aged 21 and over shall be structured, long-term services designed to assist in restoring, maintaining or increasing levels of functioning, minimizing regression, and preventing hospitalization.

(1) Service components include training in independent functioning skills necessary for self-care, emotional stability and psychosocial interactions and training in medication management.

(2) Services are structured with an emphasis on program variation according to individual need.

(3) Services are provided for a period of three to five hours per day, three or four times per week.

c. Payment will be approved for day treatment services provided by or under the general supervision of a mental health professional. When services are provided by an employee or consultant of the community mental health center who is not a mental health professional, the employee or consultant shall be supervised by a mental health professional who gives professional direction and active guidance to the employee or consultant and who retains responsibility for member care. The supervision shall be timely, regular, and documented. The employee or consultant shall meet the following minimum requirements:

(1) Have a bachelor’s degree in a human services related field from an accredited college or university; or

(2) Have an Iowa license to practice as a registered nurse with two years of experience in the delivery of nursing or human services.

d. Persons aged 18 through 20 with chronic mental illness as defined by rule 441—24.1(225A) can receive day treatment services under this subrule or subrule 78.16(7).

78.16(7) Payment to a community mental health center will be approved for day treatment services for persons aged 20 or under if the center is certified by the department for day treatment services and the services are provided on the premises of the community mental health center or satellite office of the community mental health center. Exception: Field trips away from the premises are a covered service when the trip is therapeutic and integrated into the day treatment program’s description and milieu plan.

Day treatment coverage will be limited to a maximum of 15 hours per week. Day treatment services for persons aged 20 or under shall be outpatient services provided to persons who

are not inpatients in a medical institution or residents of a group care facility licensed under 441—Chapter 114.

a. Program documentation. Community mental health centers providing day treatment services for persons aged 20 or under shall have available a written narrative that provides the following day treatment program information:

(1) Documented need for day treatment services for persons aged 20 or under in the area served by the program, including studies, needs assessments, and consultations with other health care professionals.

(2) Goals and objectives of the day treatment program for persons aged 20 or under that meet the guidelines noted in paragraphs “c” through “h” below.

(3) Organization and staffing including how the day treatment program for persons aged 20 or under fits with the rest of the community mental health center, the number of staff, staff credentials, and the staff’s relationship to the program, e.g., employee, contractual, or consultant.

(4) Policies and procedures for the program including admission criteria, patient assessment, treatment plan, discharge plan, postdischarge services, and the scope of services provided.

(5) Any accreditations or other types of approvals from national or state organizations.

(6) The physical facility and any equipment to be utilized.

b. Program standards. Medicaid day treatment program services for persons aged 20 and under shall meet the following standards:

(1) Staffing shall:

1. Be sufficient to deliver program services and provide stable, consistent, and cohesive milieu with a staff-to-patient ratio of no less than one staff for each eight participants. Clinical, professional, and paraprofessional staff may be counted in determining the staff-to-patient ratio. Professional or clinical staff are those staff who are either mental health professionals as defined in rule 441—24.1(225A) or persons employed for the purpose of providing offered services under the supervision of a mental health professional. All other staff (administrative, adjunctive, support, nonclinical, clerical, and consulting staff or professional clinical staff) when engaged in administrative or clerical activities shall not be counted in determining the staff-to-patient ratio or in defining program staffing patterns. Educational staff may be counted in the staff-to-patient ratio.

2. Reflect how program continuity will be provided.

3. Reflect an interdisciplinary team of professionals and paraprofessionals.

4. Include a designated director who is a mental health professional as defined in rule 441—24.1(225A). The director shall be responsible for direct supervision of the individual treatment plans for participants and the ongoing assessment of program effectiveness.

5. Be provided by or under the general supervision of a mental health professional. When services are provided by an employee or consultant of the community mental health center who is not a mental health professional, the employee or consultant shall be supervised by a mental health professional who gives direct professional direction and active guidance to the employee or consultant and who retains responsibility for member care. The supervision shall be timely, regular and documented. The employee or consultant shall have a bachelor’s degree in a human services related field from an accredited college or university or have an Iowa license to practice as a registered nurse with two years of experience in the delivery of nursing or human services. Exception: Other certified or licensed staff, such as certified addiction counselors or certified occupational and recreational therapy assistants, are eligible to provide direct services under the general supervision of a mental health professional, but they shall not be included in the staff-to-patient ratio.

(2) There shall be written policies and procedures addressing the following: admission criteria; patient assessment; patient evaluation; treatment plan; discharge plan; community linkage with other psychiatric, mental health, and human service providers; a process to review the quality of care being provided with a quarterly review of the effectiveness of the clinical program; postdischarge services; and the scope of services provided.

(3) The program shall have hours of operation available for a minimum of three consecutive hours per day, three days or evenings per week.

(4) The length of stay in a day treatment program for persons aged 20 or under shall not exceed 180 treatment days per episode of care, unless the rationale for a longer stay is documented in the patient's case record and treatment plan every 30 calendar days after the first 180 treatment days.

(5) Programming shall meet the individual needs of the patient. A description of services provided for patients shall be documented along with a schedule of when service activities are available including the days and hours of program availability.

(6) There shall be a written plan for accessing emergency services 24 hours a day, seven days a week.

(7) The program shall maintain a community liaison with other psychiatric, mental health, and human service providers. Formal relationships shall exist with hospitals providing inpatient programs to facilitate referral, communication, and discharge planning. Relationships shall also exist with appropriate school districts and educational cooperatives. Relationships with other entities such as physicians, hospitals, private practitioners, halfway houses, the department, juvenile justice system, community support groups, and child advocacy groups are encouraged. The provider's program description will describe how community links will be established and maintained.

(8) Psychotherapeutic treatment services and psychosocial rehabilitation services shall be available. A description of the services shall accompany the application for certification.

(9) The program shall maintain a distinct clinical record for each patient admitted. Documentation, at a minimum, shall include: the specific services rendered, the date and actual time services were rendered, who rendered the services, the setting in which the services were rendered, the amount of time it took to deliver the services, the relationship of the services to the treatment regimen described in the plan of care, and updates describing the patient's progress.

c. Program services. Day treatment services for persons aged 20 or under shall be a time-limited, goal-oriented active treatment program that offers therapeutically intensive, coordinated, structured clinical services within a stable therapeutic milieu. Time-limited means that the patient is not expected to need services indefinitely or lifelong, and that the primary goal of the program is to improve the behavioral functioning or emotional adjustment of the patient in order that the service is no longer necessary. Day treatment services shall be provided within the least restrictive therapeutically appropriate context and shall be community-based and family focused. The overall expected outcome is clinically adaptive behavior on the part of the patient and the family.

At a minimum, day treatment services will be expected to improve the patient's condition, restore the condition to the level of functioning prior to onset of illness, control symptoms, or establish and maintain a functional level to avoid further deterioration or hospitalization. Services are expected to be age-appropriate forms of psychosocial rehabilitation activities, psychotherapeutic services, social skills training, or training in basic care activities to establish, retain or encourage age-appropriate or developmentally appropriate psychosocial, educational, and emotional adjustment.

Day treatment programs shall use an integrated, comprehensive and complementary schedule of therapeutic activities and shall have the capacity to treat a wide array of clinical conditions.

The following services shall be available as components of the day treatment program. These services are not separately billable to Medicaid, as day treatment reimbursement includes reimbursement for all day treatment components.

(1) Psychotherapeutic treatment services, including individual, group, and family therapy.

(2) Psychosocial rehabilitation services. Active treatment examples include but are not limited to individual and group therapy, medication evaluation and management, expressive therapies, and theme groups such as communication skills, assertiveness training, other forms of community skills training, stress management, chemical dependency counseling, education, and prevention, symptom recognition and reduction, problem solving, relaxation techniques, and victimization (sexual, emotional, or physical abuse issues).

Other program components may be provided, such as personal hygiene, recreation, community awareness, arts and crafts, and social activities designed to improve interpersonal skills and family mental health. Although these other services may be provided, they are not the primary focus of treatment.

(3) Evaluation services to determine need for day treatment prior to program admission. For persons for whom clarification is needed to determine whether day treatment is an appropriate therapy approach, or for persons who do not clearly meet admission criteria, an evaluation service may be performed. Evaluation services shall be individual and family evaluation activities made available to courts, schools, other agencies, and individuals upon request, who assess, plan, and link individuals with appropriate services. This service must be completed by a mental health professional. An evaluation from another source performed within the previous 12 months or sooner if there has not been a change may be substituted. Medicaid will not make separate payment for these services under the day treatment program.

(4) Assessment services. All day treatment patients will receive a formal, comprehensive biopsychosocial assessment of day treatment needs including, if applicable, a diagnostic impression based on the Diagnostic and Statistical Manual of Mental Disorders as amended to July 1, 2026. An assessment from another source performed within the previous 12 months may be used if the symptomatology is the same as 12 months ago. If not, parts of the assessment that reflect current functioning may be used as an update. Using the assessment, a comprehensive summation will be produced, including the findings of all assessments performed. The summary will be used in forming a treatment plan including treatment goals. Indicators for discharge planning, including recommended follow-up goals and provision for future services, should also be considered, and consistently monitored.

(5) The day treatment program may include an educational component as an additional service. The patient's educational needs shall be served without conflict from the day treatment program. Hours in which the patient is involved in the educational component of the day treatment program are not included in the day treatment hours billable to Medicaid.

d. Admission criteria. Admission criteria for day treatment services for persons aged 20 or under shall reflect the following clinical indicators:

- (1) The patient is at risk for exclusion from normative community activities or residence.
- (2) The patient exhibits psychiatric symptoms, disturbances of conduct, decompensating conditions affecting mental health, severe developmental delays, psychological symptoms, or chemical dependency issues sufficiently severe to bring about significant or profound impairment in day-to-day educational, social, vocational, or interpersonal functioning.
- (3) Documentation is provided that the traditional outpatient setting has been considered and has been determined not to be appropriate.

(4) The patient's principal caretaker (family, guardian, foster family or custodian) must be able and willing to provide the support and monitoring of the patient, to enable adequate control of the patient's behavior, and must be involved in the patient's treatment. Persons aged 20 or under who have reached the age of majority, either by age or emancipation, are exempt from family therapy involvement.

- (5) The patient has the capacity to benefit from the interventions provided.

e. Individual treatment plan. Each patient receiving day treatment services shall have a treatment plan prepared. A preliminary treatment plan should be formulated within 3 days of participation after admission, and replaced within 30 calendar days by a comprehensive, formalized plan utilizing the comprehensive assessment. This individual treatment plan should reflect the patient's strengths and weaknesses and identify areas of therapeutic focus. The treatment goals that are general statements of member outcomes shall be related to identified strengths, weaknesses, and clinical needs with time-limited, measurable objectives. Objectives shall be related to the goal and have specific anticipated outcomes. Methods that will be used to pursue the objectives shall be stated. The plan should be reviewed and revised as needed, but shall be reviewed at least every 30 calendar

days. The treatment plan shall be developed or approved by a board-eligible or board-certified psychiatrist, a staff psychiatrist, physician, or a psychologist registered on the “National Register of Health Service Providers in Psychology” as amended to July 1, 2026. Approval will be evidenced by a signature of the physician or health service provider.

f. Discharge criteria. Discharge criteria for the day treatment program for persons aged 20 or under shall incorporate at least the following indicators:

(1) In the case of patient improvement:

1. The patient’s clinical condition has improved as shown by symptom relief, behavioral control, or indication of mastery of skills at the patient’s developmental level. Reduced interference with and increased responsibility with social, vocational, interpersonal, or educational goals occurs sufficient to warrant a treatment program of less supervision, support, and therapeutic intervention.

2. Treatment goals in the individualized treatment plan have been achieved.

3. An aftercare plan has been developed that is appropriate to the patient’s needs and agreed to by the patient and family, custodian, or guardian.

(2) If the patient does not improve:

1. The patient’s clinical condition has deteriorated to the extent that the safety and security of inpatient or residential care is necessary.

2. Patient, family, or custodian noncompliance with treatment or with program rules exists.

g. Coordination of services. Programming services shall be provided in accordance with the individual treatment plan developed by appropriate day treatment staff, in collaboration with the patient and appropriate caretaker figure (parent, guardian, or principal caretaker), and under the supervision of the program director, coordinator, or supervisor.

(1) The program for each patient will be coordinated by primary care staff of the community mental health center. A coordinated, consistent array of scheduled therapeutic services and activities shall comprise the day treatment program. These may include counseling or psychotherapy, theme groups, social skills development, behavior management, and other adjunctive therapies. At least 50 percent of scheduled therapeutic program hours exclusive of educational hours for each patient shall consist of active treatment that specifically addresses the targeted problems of the population served. Active treatment shall be defined as treatment in which the program staff assume significant responsibility and often intervene.

(2) Family, guardian, or principal caretaker shall be involved with the program through family therapy sessions or scheduled family components of the program. They will be encouraged to adopt an active role in treatment. Medicaid will not make separate payment for family therapy services. Persons aged 20 or under who have reached the age of majority, either by age or emancipation, are exempt from family therapy involvement.

(3) Therapeutic activities will be scheduled according to the needs of the patients, both individually and as a group.

(4) Scheduled therapeutic activities, which may include other program components as described above, shall be provided at least 3 hours per week up to a maximum of 15 hours per week.

h. Stable milieu. The program shall formally seek to provide a stable, consistent, and cohesive therapeutic milieu. In part this will be encouraged by scheduling attendance such that a stable core of patients exists as much as possible. The milieu will consider the developmental and social stage of the participants such that no patient will be significantly involved with other patients who are likely to contribute to retardation or deterioration of the patient’s social and emotional functioning. To help establish a sense of program identity, the array of therapeutic interventions shall be specifically identified as the day treatment program. Program planning meetings shall be held at least quarterly to evaluate the effectiveness of the clinical program. In the program description, the provider shall state how milieu stability will be provided.

i. Chronic mental illness. Persons aged 18 through 20 with chronic mental illness as defined by rule 441—24.1(225A) can receive day treatment services under this subrule or subrule 78.16(6).

[ARC 0315D, IAB 5/27/26, effective 7/1/26]

441—78.17(249A) Physical therapists. Payment will be approved when the services provided relate directly to an active written treatment plan; follow a treatment plan established by the physician, nurse practitioner, clinical nurse specialist, or PA after any needed consultation with the qualified physical therapist; are reasonable and necessary to the treatment of the patient's illness or injury; and meet the guidelines defined for restorative, maintenance, or trial therapy as set forth in paragraphs 78.19(1) "a" and "b."

[ARC 0315D, IAB 5/27/26, effective 7/1/26]

441—78.18(249A) Screening centers. Payment will be approved for health screening as defined in rule 441—84.1(249A) for Medicaid members under 21 years of age.

78.18(1) In order to be paid for the administration of a vaccine covered under the VFC program, a screening center must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

78.18(2) Payment will be approved for necessary laboratory service related to an element of screening when performed by the screening center and billed as a separate item.

78.18(3) Periodicity schedules for health, hearing, vision, and dental screenings.

a. Payment will be approved for health, vision, and hearing screenings as follows:

- (1) Seven screenings in the first year of life.
- (2) Four screenings between the ages of 13 months and 30 months.
- (3) One screening per year at ages three, four, five, and six.
- (4) One screening per year at ages 7 through 21.

b. Payment for dental screenings will be approved in conjunction with the health screenings up to age 12 months. Screenings will be approved at ages 12 months and 24 months and thereafter at six-month intervals up to age 21.

c. Interperiodic screenings will be approved as medically necessary.

78.18(4) When it is established by the periodicity schedule in 78.18(3) that an individual is in need of screening, the individual will receive a notice that screening is due.

78.18(5) When an individual is screened, a member of the screening center shall complete a medical history. The medical history shall become part of the individual's medical record.

78.18(6) Reserved.

78.18(7) Payment will be made for persons aged 20 and under for nutritional counseling provided by a licensed dietitian employed by or under contract with a screening center for a nutritional problem or condition of a degree of severity that nutritional counseling beyond that normally expected as part of the standard medical management is warranted. For persons eligible for the WIC program, a WIC referral is required. Medical necessity for nutritional counseling services exceeding those available through WIC shall be documented.

78.18(8) Payment will be made for dental services provided by a dental hygienist employed by or under contract with a screening center.

[ARC 0315D, IAB 5/27/26, effective 7/1/26]

441—78.19(249A) Rehabilitation agencies.

78.19(1) *Coverage of services.*

a. *General provisions regarding coverage of services.*

(1) Services are provided in the member's home or in a care facility (other than a hospital) by a speech therapist, physical therapist, or occupational therapist employed by or contracted by the agency. A nursing facility, an ICF/ID, or a hospital where services are provided is not considered a member's home.

1. Services provided to a member residing in a residential care facility licensed under Iowa Code section 135C.4 by the department of inspections, appeals, and licensing are payable when the residential care facility submits a signed statement that the residential care facility does not have these services available. The statement need only be submitted at the start of care unless the situation changes.

2. Under no circumstances will Iowa Medicaid or managed care organizations (MCOs) make payments to a rehabilitation agency for therapy provided to a member residing in a nursing facility or an ICF/ID. Physical, occupational, and speech therapy services for residents of the nursing facility, ICF/ID, or hospital are the responsibility of the nursing facility, ICF/ID, or hospital.

(2) All services must be determined to be medically necessary, reasonable, and meet a significant need of the recipient that cannot be met by a family member, friend, medical staff personnel, or other caregiver; must meet accepted standards of medical practice; and must be a specific and effective treatment for a patient's medical or disabling condition.

(3) In order for a service to be payable, a licensed therapist must complete a plan of treatment every 30 days and indicate the type of service required. The plan of treatment must contain the information noted in subrule 78.19(2).

(4) There is no specific limitation on the number of visits for which payment through the program will be made so long as that amount of service is medically necessary in the individual case, is related to a diagnosed medical impairment or disabling condition and meets the current standards of practice in each related field. Documentation must be submitted with each claim to support the need for the number of services being provided.

(5) Payments will be made both for restorative service and also for maintenance types of service. Essentially, maintenance services means services to a patient whose condition is stabilized and who requires observation by a therapist of conditions defined by the physician as indicating a possible deterioration of health status. This would include persons with long-term illnesses or a disabling condition whose status is stable rather than posthospital. Refer to subparagraphs 78.19(1) "b"(7) and "b"(8) for guidelines under restorative and maintenance therapy.

(6) Restorative or maintenance therapy sessions must meet the following criteria:

1. There must be face-to-face patient contact interaction.
2. Services must be provided primarily on an individual basis. Group therapy is covered, but total units of service in a month shall not exceed total units of individual therapy. Family members receiving therapy may be included as part of a group.

3. Treatment sessions may be no less than 15 minutes of service and no more than 60 minutes of service per date unless more than 60 minutes of service is required for a treatment session due to the patient's specific condition. If more than 60 minutes of service is required for a treatment session, additional documentation of the specific condition and the need for the longer treatment session shall be submitted with the claim. A unit of treatment shall be considered to be 15 minutes unless an untimed or encounter billing code is used.

4. Progress must be documented in measurable statistics in the progress notes in order for services to be reimbursed. Refer to subparagraphs 78.19(1) "b"(7) and "b"(8) for guidelines under restorative and maintenance therapy.

(7) Payment will be made for an appropriate period of diagnostic therapy or trial therapy (up to two months) to determine a patient's rehabilitation potential and establish appropriate short-term and long-term goals. Documentation must be submitted with each plan to support the need for diagnostic or trial therapy. Refer to subparagraph 78.19(1) "b"(16) for guidelines under diagnostic or trial therapy.

b. Physical therapy services.

- (1) To be covered under rehabilitation agency services, physical therapy services must relate directly and specifically to an active written treatment plan, follow a treatment plan established by the licensed therapist after consultation with the physician, be reasonable and necessary to the treatment of the person's illness, injury, or disabling condition, be specific and effective treatment for the patient's medical or disabling condition, and be of such a level of complexity and sophistication, or the condition of the patient must be such that the services required can be safely and effectively performed only by a qualified physical therapist or under the supervision of the therapist.

- (2) A qualified physical therapist assistant may provide any restorative services performed by a licensed physical therapist under supervision of the therapist.

- (3) The initial physical therapy evaluation must be provided by a licensed physical therapist.
- (4) There must be an expectation that there will be a significant, practical improvement in the patient's condition in a reasonable amount of time based on the patient's restorative potential assessed by the physician.
- (5) It must be demonstrated there is a need to establish a safe and effective maintenance program related to a specific disease state, illness, injury, or disabling condition.
- (6) The amount, frequency, and duration of the services must be reasonable.
- (7) Restorative therapy must be reasonable and necessary to the treatment of the patient's injury or disabling condition. The expected restorative potential must be practical and in relation to the extent and duration of the treatment. There must be an expectation that the patient's medical or disabling condition will show functional improvement in a reasonable period of time. Functional improvement means that demonstrable measurable increases have occurred in the patient's level of independence outside the therapeutic environment.
- (8) Generally, maintenance therapy means services to a patient whose condition is stabilized and who requires observation by a therapist of conditions defined by the physician as indicating a possible deterioration of health status. This includes persons with long-term illnesses or disabling conditions whose status is stable rather than posthospital. Maintenance therapy is also appropriate for individuals whose condition is such that a professionally established program of activities, exercises, or stimulation is medically necessary to prevent deterioration or maintain present functioning levels.
 1. Where a maintenance program is appropriate, the initial evaluation and the instruction of the patient, family members, home health aides, facility personnel, or other caregivers to carry out the program are considered a covered physical therapy service. Payment shall be made for a maximum of three visits to establish a maintenance program and instruct the caregivers. Payment for supervisory visits to monitor the program is limited to two per month for a maximum period of 12 months. The plan of treatment must specify the anticipated monitoring activity of the supervisor.
 2. Beyond evaluation, instruction, and monitoring, maintenance therapy is not reimbursable.
 3. After 12 months of maintenance therapy, a reevaluation is a covered service, if medically necessary. A reevaluation will be considered medically necessary only if there is a significant change in residential or employment situation or the patient exhibits an increase or decrease in functional ability or motivation, clearing of confusion, or the remission of some other medical condition which previously contraindicated restorative therapy. A statement by the interdisciplinary team of a person with developmental disabilities recommending a reevaluation and stating the basis for medical necessity will be considered as supporting the necessity of a reevaluation and may expedite approval.

(Restorative and maintenance therapy definitions also apply to speech and occupational therapy.)
 4. When a patient is under a restorative physical therapy program, the patient's condition is regularly reevaluated and the program adjusted by the physical therapist. It is expected that prior to discharge, a maintenance program has been designed by the physical therapist. Consequently, where a maintenance program is not established until after the restorative program has been completed, it would not be considered reasonable and necessary to the treatment of the patient's condition and would be excluded from coverage.
- (9) Hot packs, hydrocollator, infrared treatments, paraffin baths, and whirlpool baths do not ordinarily require the skills of a qualified physical therapist. These are covered when the patient's condition is complicated by other conditions such as a circulatory deficiency or open wounds or if the service is an integral part of a skilled physical therapy procedure.
- (10) Gait training and gait evaluation and training constitute a covered service if the patient's ability to walk has been impaired by a neurological, muscular or skeletal condition or illness. The gait training must be expected to significantly improve the patient's ability to walk or level of independence.

Repetitious exercise to increase endurance of weak or unstable patients can be safely provided by supportive personnel, e.g., aides, nursing personnel. Therefore, it is not a covered physical therapy service.

(11) Ultrasound, shortwave, and microwave diathermy treatments are considered covered services.

(12) Range of motion tests must be performed by a qualified physical therapist. Range of motion exercises require the skills of a qualified physical therapist only when they are part of the active treatment of a specific disease or disabling condition which has resulted in a loss or restriction of mobility.

Documentation must reflect the degree of motion lost, the normal range of motion, and the degree to be restored.

Range of motion to unaffected joints only does not constitute a covered physical therapy service.

(13) Reconditioning programs after surgery or prolonged hospitalization are not covered as physical therapy.

(14) Therapeutic exercises would constitute a physical therapy service due either to the type of exercise employed or to the condition of the patient.

(15) Use of isokinetic or isotonic type equipment in physical therapy is covered when normal range of motion of a joint is affected due to bone, joint, ligament or tendon injury or postsurgical trauma. Billing can only be made for the time actually spent by the therapist in instructing the patient and assessing the patient's progress.

(16) When recipients do not meet restorative or maintenance therapy criteria, diagnostic or trial therapy may be utilized. When the initial evaluation is not sufficient to determine whether there are rehabilitative goals that should be addressed, diagnostic or trial therapy to establish goals will be considered appropriate. Diagnostic or trial therapy may be appropriate for recipients who need evaluation in multiple environments in order to adequately determine their rehabilitative potential. Diagnostic or trial therapy consideration may be appropriate when there is a need to assess the patient's response to treatment in the recipient's environment.

1. When during diagnostic or trial therapy a recipient has been sufficiently evaluated to determine potential for restorative or maintenance therapy, or lack of therapy potential, diagnostic or trial therapy ends. When as a result of diagnostic or trial therapy, restorative or maintenance therapy is found appropriate, claims shall be submitted noting restorative or maintenance therapy (instead of diagnostic or trial therapy).

2. At the end of diagnostic or trial therapy, the rehabilitation provider shall recommend continuance of services under restorative therapy, recommend continuance of services under maintenance therapy, or recommend discontinuance of services. Continuance of services under restorative or maintenance therapy will be reviewed based on the criteria in place for restorative or maintenance therapy.

3. Trial therapy shall not be granted more often than once per year for the same issue. If the recipient has a previous history of rehabilitative services, trial therapy for the same type of services generally would be payable only when a significant change has occurred since the last therapy. Requests for subsequent diagnostic or trial therapy for the same issue would require documentation reflecting a significant change. See numbered paragraph "4" below for guidelines under a significant change. Further diagnostic or trial therapy for the same issue would not be considered appropriate when progress was not achieved unless the reasons that blocked change previously are listed and the reasons the new diagnostic or trial therapy would not have these blocks are provided.

4. The number of diagnostic or trial therapy hours authorized in the initial treatment period shall not exceed 12 hours per month. Documentation of the medical necessity and the plan for services under diagnostic trial therapy are required as they will be reviewed in the determination of the medical necessity of the number of hours of service provided.

Diagnostic or trial therapy standards also apply to speech and occupational therapy.

The following criteria additionally must be met:

- There must be face-to-face interaction with a licensed therapist. (An aide's services will not be payable.)

- Services must be provided on an individual basis. (Group diagnostic or trial therapy will not be payable.)

- Documentation of the diagnostic therapy or trial therapy must reflect the provider's plan for therapy and the recipient's response.

- If the recipient has a previous history of rehabilitative services, trial therapy for the same type of services generally would be payable only when a significant change has occurred since the last therapy. A significant change would be considered as having occurred when any of the following exist: new onset, new problem, new need, new growth issue, a change in vocational or residential setting that requires a reevaluation of potential, or surgical intervention that may have caused new rehabilitative potentials.

- For persons who received previous rehabilitative treatment, consideration of trial therapy generally should occur only if the person has incorporated any regimen recommended during prior treatment into the person's daily life to the extent of the person's abilities.

- Documentation should include any previous attempts to resolve problems using nontherapy personnel (residential group home staff, family members, etc.) and whether follow-up programs from previous therapy have been carried out.

- Referrals from residential, vocational or other rehabilitation personnel that do not meet present evaluation, restorative or maintenance criteria shall be considered for trial therapy. Documentation of the proposed service, the medical necessity and the current medical or disabling condition, including any secondary rehabilitative diagnosis, will need to be submitted with the claim.

- Claims for diagnostic or trial therapy shall reflect the progress being made toward the initial diagnostic or trial therapy plan.

c. Occupational therapy services.

(1) To be covered under rehabilitation agency services, occupational therapy services must be included in a plan of treatment, improve or restore practical functions that have been impaired by illness, injury, or disabling condition, or enhance the person's ability to perform those tasks required for independent functioning, be prescribed by a physician under a plan of treatment, be performed by a qualified licensed occupational therapist or a qualified licensed occupational therapist assistant under the general supervision of a qualified licensed occupational therapist, and be reasonable and necessary for the treatment of the person's illness, injury, or disabling condition.

(2) Restorative therapy is covered when an expectation exists that the therapy will result in a significant practical improvement in the person's condition.

However, in these cases where there is a valid expectation of improvement met at the time the occupational therapy program is instituted, but the expectation goal is not realized, services would only be covered up to the time one would reasonably conclude the patient would not improve.

The guidelines under restorative therapy, maintenance therapy, and diagnostic or trial therapy for physical therapy in subparagraphs 78.19(1) "b"(7), "b"(8), and "b"(16) apply to occupational therapy.

(3) Maintenance therapy, or any activity or exercise program required to maintain a function at the restored level, is not a covered service. However, designing a maintenance program in accordance with the requirements of subparagraph 78.19(1) "b"(8) and monitoring the progress would be covered.

(4) The selection and teaching of tasks designed to restore physical function are covered.

(5) Planning and implementing therapeutic tasks, such as activities to restore sensory-integrative functions are covered. Other examples include providing motor and tactile activities to increase input and improve responses for a stroke patient.

(6) The teaching of activities of daily living and energy conservation to improve the level of independence of a patient that require the skill of a licensed therapist and meet the definition of restorative therapy is covered.

(7) The designing, fabricating, and fitting of orthotic and self-help devices are considered covered services if they relate to the patient's condition and require occupational therapy. A maximum of 13 visits is reimbursable.

(8) Vocational and prevocational assessment and training are not payable by Medicaid. These include services that are related solely to specific employment opportunities, work skills, or work settings.

d. Speech therapy services.

(1) To be covered by Medicaid as rehabilitation agency services, speech therapy services must be included in a plan of treatment established by the licensed, skilled therapist after consultation with the physician, relate to a specific medical diagnosis that will significantly improve a patient's practical, functional level in a reasonable and predictable time period, and require the skilled services of a speech therapist. Services provided by a speech aide are not reimbursable.

(2) Speech therapy activities that are considered covered services include: restorative therapy services to restore functions affected by illness, injury, or disabling condition resulting in a communication impairment or to develop functions where deficiencies currently exist. Communication impairments fall into the general categories of disorders of voice, fluency, articulation, language, and swallowing disorders resulting from any condition other than mental impairment. Treatment of these conditions is payable if restorative criteria are met.

(3) Aural rehabilitation, the instruction given by a qualified speech pathologist in speech reading or lip reading to patients who have suffered a hearing loss or become hard of hearing (input impairment), constitutes a covered service if reasonable and necessary to the patient's illness or injury. Group treatment is not covered. Audiological services related to the use of a hearing aid are not reimbursable.

(4) Teaching a patient to use sign language and to use an augmentative communication device is reimbursable. The patient must show significant progress outside the therapy sessions in order for these services to be reimbursable.

(5) Where a maintenance program is appropriate, the initial evaluation, the instruction of the patient and caregivers to carry out the program, and supervisory visits to monitor progress are covered services. Beyond evaluation, instruction, and monitoring, maintenance therapy is not reimbursable. However, designing a maintenance program in accordance with the requirements of maintenance therapy and monitoring the progress are covered.

(6) The guidelines and limits on restorative therapy, maintenance therapy, and diagnostic or trial therapy for physical therapy in subparagraphs 78.19(1) "b"(7), "b"(8), and "b"(16) apply to speech therapy. If the only goal of prior rehabilitative speech therapy was to learn the prerequisite speech components, then the fifth paragraph under subparagraph 78.19(1) "b"(16) will not apply to trial therapy.

78.19(2) *General guidelines for plans of treatment.*

a. The minimum information to be included on medical information forms and treatment plans includes:

(1) The patient's current medical condition and functional abilities, including any disabling condition.

(2) The physician's signature and date (within the certification period).

(3) Certification period.

(4) Patient's progress in measurable statistics. (Refer to subparagraph 78.19(1) "b"(16).)

(5) The place services are rendered.

(6) Dates of prior hospitalization (if applicable or known).

(7) Dates of prior surgery (if applicable or known).

(8) The date the patient was last seen by the physician (if available).

(9) A diagnosis relevant to the medical necessity for treatment.

(10) Dates of onset of any diagnoses for which treatment is being rendered (if applicable).

(11) A brief summary of the initial evaluation or baseline.

(12) The patient's prognosis.

(13) The services to be rendered.

(14) The frequency of the services and discipline of the person providing the service.

(15) The anticipated duration of the services and the estimated date of discharge (if applicable).

(16) Assistive devices to be used.

(17) Functional limitations.

(18) The patient's rehabilitative potential and the extent to which the patient has been able to apply the skills learned in the rehabilitation setting to everyday living outside the therapy sessions.

(19) The date of the last episode of instability or the date of the last episode of acute recurrence of illness or symptoms (if applicable).

(20) Quantitative, measurable, short-term and long-term functional goals.

(21) The period of time of a session.

(22) Prior treatment (history related to current diagnosis) if available or known.

b. The information to be included when developing plans for teaching, training, and counseling include:

(1) To whom the services were provided (patient, family member, etc.).

(2) Prior teaching, training, or counseling provided.

(3) The medical necessity of the rendered services.

(4) The identification of specific services and goals.

(5) The date of the start of the services.

(6) The frequency of the services.

(7) Progress in response to the services.

(8) The estimated length of time the services are needed.

[ARC 0315D, IAB 5/27/26, effective 7/1/26]

441—78.20(249A) Independent laboratories. Payment will be made for medically necessary laboratory services provided by laboratories that are independent of attending and consulting physicians' offices, hospitals, and critical access hospitals and that are certified to participate in the Medicare program.

[ARC 0315D, IAB 5/27/26, effective 7/1/26]

441—78.21(249A) Rural health clinics. Payment will be made to rural health clinics for the same services payable under the Medicare program. Payment will be made for sterilization in accordance with subrule 78.1(16).

78.21(1) Utilization review. Utilization review will be conducted for Medicaid members who access more than 24 outpatient visits in any 12-month period from physicians, ARNPs, federally qualified health centers, other clinics, and emergency rooms.

78.21(2) Risk assessment. Risk assessment, using a Medicaid Prenatal Risk Assessment form, shall be completed at the initial visit during a Medicaid member's pregnancy.

a. If the risk assessment reflects a low-risk pregnancy, the assessment shall be completed again at approximately the twenty-eighth week of pregnancy.

b. If the risk assessment reflects a high-risk pregnancy, referral shall be made for enhanced services described in subrule 78.25(3).

78.21(3) Vaccines. In order to be paid for the administration of a vaccine covered under the VFC program, a rural health center must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

[ARC 0315D, IAB 5/27/26, effective 7/1/26]

441—78.22(249A) Family planning clinics. Payments will be made on a fee schedule basis for services provided by family planning clinics.

78.22(1) Payment will be made for sterilization in accordance with subrule 78.1(16).

78.22(2) In order to be paid for the administration of a vaccine covered under the VFC program, a family planning clinic must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

[ARC 0315D, IAB 5/27/26, effective 7/1/26]

441—78.23(249A) Other clinic services. Payment will be made on a fee schedule basis to facilities not part of a hospital, funded publicly or by private contributions, that provide medically necessary treatment by or under the direct supervision of a physician or dentist to outpatients.

78.23(1) Sterilization. Payment will be made for sterilization in accordance with subrule 78.1(16).

78.23(2) Utilization review. Utilization review will be conducted for Medicaid members who access more than 24 outpatient visits in any 12-month period from physicians, ARNPs, federally qualified health centers, other clinics, and emergency rooms.

78.23(3) Risk assessment. Risk assessment, using a Medicaid Prenatal Risk Assessment form, shall be completed at the initial visit during a Medicaid member's pregnancy.

a. If the risk assessment reflects a low-risk pregnancy, the assessment shall be completed again at approximately the twenty-eighth week of pregnancy.

b. If the risk assessment reflects a high-risk pregnancy, referral shall be made for enhanced services described in subrule 78.25(3).

78.23(4) Vaccines. In order to be paid for the administration of a vaccine covered under the VFC program, a clinic must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

[ARC 0315D, IAB 5/27/26, effective 7/1/26]

441—78.24(249A) Psychologists. Payment will be approved for services authorized by state law when they are provided by the psychologist in the psychologist's office, a hospital, nursing facility, or residential care facility.

78.24(1) Payment for covered services provided by the psychologist will be made on a fee for service basis.

a. Payment will be made only for time spent in face-to-face consultation with the client.

b. Time spent with clients shall be rounded to the quarter hour.

78.24(2) Payment will be approved for the following psychological procedures:

a. Individual outpatient psychotherapy or other psychological procedures not to exceed one hour per week or 40 hours in any 12-month period, or

b. Couple, marital, family, or group outpatient therapy not to exceed one and one-half hours per week or 60 hours in any 12-month period, or

c. A combination of individual and group therapy not to exceed the cost of 40 individual therapy hours in any 12-month period.

d. Psychological examinations and testing for purposes of evaluation, placement, psychotherapy, or assessment of therapeutic progress, not to exceed eight hours in any 12-month period.

e. Mileage at the same rate as in subrule 78.1(8) when the following conditions are met:

(1) It is necessary for the psychologist to travel outside of the home community, and

(2) There is no qualified mental health professional more immediately available in the community, and

(3) The member has a medical condition which prohibits travel.

f. Covered procedures necessary to maintain continuity of psychological treatment during periods of hospitalization or convalescence for physical illness.

g. Procedures provided within a licensed hospital, residential treatment facility, day hospital, or nursing home as part of an approved treatment plan and a psychologist is not employed by the facility.

78.24(3) Payment will not be approved for the following services:

a. Psychological examinations performed without relationship to evaluations or psychotherapy for a specific condition, symptom, or complaint.

b. Psychological examinations covered under Part B of Medicare, except for the Part B Medicare deductible and coinsurance.

c. Psychological examinations employing unusual or experimental instrumentation.

d. Individual and group psychotherapy without specification of condition, symptom, or complaint.

e. Sensitivity training, marriage enrichment, assertiveness training, growth groups or marathons, or psychotherapy for nonspecific conditions of distress such as job dissatisfaction or general unhappiness.

78.24(4) Reserved.

78.24(5) The following services shall require review by a consultant to the department.

a. Protracted therapy beyond 16 visits. These cases shall be reviewed following the sixteenth therapy session and periodically thereafter.

b. Any service that does not appear necessary or appears to fall outside the scope of what is professionally appropriate or necessary for a particular condition.

[ARC 0315D, IAB 5/27/26, effective 7/1/26]

441—78.25(249A) Maternal health centers. Payment will be made for prenatal and postpartum medical care, health education, and transportation to receive prenatal and postpartum services. Payment will be made for enhanced perinatal services for persons determined high risk. These services include additional health education services, nutrition counseling, social services, and one postpartum home visit. Maternal health centers shall provide trimester and postpartum reports to the referring physician. Risk assessment using a Medicaid Prenatal Risk Assessment form shall be completed at the initial visit during a Medicaid member's pregnancy. If the risk assessment reflects a low-risk pregnancy, the assessment shall be completed again at approximately the twenty-eighth week of pregnancy. If the risk assessment reflects a high-risk pregnancy, referral shall be made for enhanced services described in subrule 78.25(3).

78.25(1) Provider qualifications.

a. Prenatal and postpartum medical services shall be provided by a physician, a PA, or a nurse practitioner employed by or on contract with the center. Medical services performed by maternal health centers shall be performed under the supervision of a physician. Nurse practitioners and PAs performing under the supervision of a physician must do so within the scope of practice of that profession, as defined by Iowa Code chapters 152 and 148C, respectively.

b. Reserved.

c. Education services and postpartum home visits shall be provided by a registered nurse.

d. Nutrition services shall be provided by a licensed dietitian.

e. Psychosocial services shall be provided by a person with at least a bachelor's degree in social work, counseling, sociology, psychology, family and community services, health or human development, health education, or individual and family studies.

78.25(2) Services covered for all pregnant women. Services provided may include:

a. Prenatal and postpartum medical care.

b. Health education, which will include:

(1) Importance of continued prenatal care.

(2) Normal changes of pregnancy including both maternal changes and fetal changes.

(3) Self-care during pregnancy.

(4) Comfort measures during pregnancy.

(5) Danger signs during pregnancy.

(6) Labor and delivery including the normal process of labor, signs of labor, coping skills, danger signs, and management of labor.

(7) Preparation for baby including feeding, equipment, and clothing.

(8) Education on the use of over-the-counter drugs.

(9) Education about HIV protection.

c. Home visit.

d. Transportation to receive prenatal and postpartum services that is not payable under rule 441—78.11(249A) or 441—78.13(249A).

e. Dental hygiene services within the scope of practice as defined by the dental board in 481—Chapter 576.

78.25(3) *Enhanced services covered for women with high-risk pregnancies.* Enhanced perinatal services may be provided to a patient who has been determined to have a high-risk pregnancy as documented on the Medicaid Prenatal Risk Assessment form. An appropriately trained physician or ARNP must be involved in staffing the patients receiving enhanced services.

Enhanced services are as follows:

- a. Reserved.
- b. Education, which shall include as appropriate education about the following:
 - (1) High-risk medical conditions.
 - (2) High-risk sexual behavior.
 - (3) Smoking cessation.
 - (4) Alcohol usage education.
 - (5) Drug usage education.
 - (6) Environmental and occupational hazards.
- c. Nutrition assessment and counseling, which shall include:
 - (1) Initial assessment of nutritional risk based on height, current and prepregnancy weight status, laboratory data, clinical data, and self-reported dietary information.
 - (2) Ongoing nutritional assessment.
 - (3) Development of an individualized nutritional care plan.
 - (4) Referral to food assistance programs if indicated.
 - (5) Nutritional intervention.
- d. Psychosocial assessment and counseling, which shall include:
 - (1) A psychosocial assessment including: needs assessment, profile of client demographic factors, mental and physical health history and concerns, adjustment to pregnancy and future parenting, and environmental needs.
 - (2) A profile of the client's family composition, patterns of functioning and support systems.
 - (3) An assessment-based plan of care, risk tracking, counseling and anticipatory guidance as appropriate, and referral and follow-up services.
- e. A postpartum home visit within two weeks of the child's discharge from the hospital, which shall include:
 - (1) Assessment of mother's health status.
 - (2) Physical and emotional changes postpartum.
 - (3) Family planning.
 - (4) Parenting skills.
 - (5) Assessment of infant health.
 - (6) Infant care.
 - (7) Grief support for unhealthy outcome.
 - (8) Parenting of a preterm infant.
 - (9) Identification of and referral to community resources as needed.

78.25(4) *Vaccines.* In order to be paid for the administration of a vaccine covered under the VFC program, a maternal health center must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

[ARC 0315D, IAB 5/27/26, effective 7/1/26]

441—78.26(249A) Ambulatory surgical center services. Ambulatory surgical center services are those services furnished by an ambulatory surgical center in connection with a covered surgical procedure or a covered dental procedure. Covered procedures are listed in the fee schedule published on the department's website.

78.26(1) Covered surgical procedures will be those medically necessary procedures that are eligible for payment as physicians' services, under the circumstances specified in rule

441—78.1(249A) and performed on a Medicaid member, that can safely be performed in an outpatient setting as determined by the department.

78.26(2) Covered dental procedures are those medically necessary procedures that are eligible for payment as dentists' services, under the circumstances specified in rule 441—78.4(249A) and performed on a Medicaid member, that can safely be performed in an outpatient setting for Medicaid members whose mental, physical, or emotional condition necessitates deep sedation or general anesthesia.

78.26(3) The covered services provided by the ambulatory surgical center in connection with a Medicaid-covered surgical or dental procedure will be those nonsurgical and nondental services that:

- a. Are medically necessary in connection with a Medicaid-covered surgical or dental procedure;
- b. Are eligible for payment as physicians' services under the circumstances specified in rule 441—78.1(249A) or as dentists' services under the circumstances specified in rule 441—78.4(249A); and
- c. Can safely and economically be performed in an outpatient setting, as determined by the department.

78.26(4) Limits on covered services.

- a. Abortion procedures are covered only when criteria in subrule 78.1(17) are met.
- b. Sterilization procedures are covered only when criteria in subrule 78.1(16) are met.
- c. Preprocedure review by Iowa Medicaid is required if ambulatory surgical centers are to be reimbursed for certain frequently performed surgical procedures as set forth under subrule 78.1(19). Criteria are available from Iowa Medicaid.

[ARC 0315D, IAB 5/27/26, effective 7/1/26]

441—78.27(249A) Home- and community-based habilitation services. Payment for habilitation services will only be made to providers enrolled to provide habilitation through Iowa Medicaid. Payment will only be made for services provided to members in integrated, community-based settings that support full access of members receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.

78.27(1) Definitions.

“Adult” means a person who is 18 years of age or older.

“Assessment” means the review of the current functioning of the member using the service in regard to the member's situation, needs, strengths, abilities, desires, and goals.

“Benefits education” means providing basic information to understand and access appropriate resources to pursue employment, and knowledge of work incentives and the Medicaid for employed persons with disabilities (MEPD) program. Benefits education may include gathering information needed to pursue work incentives and offering basic financial management information to members, families, guardians and legal representatives.

“Career exploration,” also referred to as “career planning,” means a person-centered, comprehensive employment planning and support service that provides assistance for waiver program participants to obtain, maintain or advance in competitive employment or self-employment. Career exploration is a focused, time-limited service engaging a participant in identifying a career direction and developing a plan for achieving competitive, integrated employment at or above the state's minimum wage. The outcome of this service is documentation of the participant's stated career objective and a career plan used to guide individual employment support.

“Career plan” means a written plan documenting the member's stated career objective and used to guide individual employment support services for achieving competitive, integrated employment at or above the state's minimum wage.

“Case management” means case management services accredited under 441—Chapter 24 and provided according to 441—Chapter 90.

“Certified employment specialist” or *“CES”* means a person who has demonstrated a sufficient level of knowledge and skill to provide integrated employment support services to a variety of client populations and has earned a CES certification through a nationally recognized accrediting body.

“Child and Adolescent Level of Care Utilization System” or *“CALOCUS”* means the comprehensive functional assessment tool utilized to determine eligibility for the habilitation program and service authorization for the home-based habilitation service and intensive residential habilitation services for individuals aged 16 to 18.

“Comprehensive service plan” means an individualized, person-centered, and goal-oriented plan of services written in language understandable by the member using the service and developed collaboratively by the member and the case manager.

“Customized employment” means an approach to supported employment that individualizes the employment relationship between employees and employers in ways that meet the needs of both. Customized employment is based on an individualized determination of the strengths, needs, and interests of the person with a disability and is also designed to meet the specific needs of the employer. Customized employment may include employment developed through job carving, self-employment or entrepreneurial initiatives, or other job development or restructuring strategies that result in job responsibilities being customized and individually negotiated to fit the needs of the individual with a disability. Customized employment assumes the provision of reasonable accommodations and supports necessary for the individual to perform the functions of a job that is individually negotiated and developed.

“Emergency” means a situation for which no approved individual program plan exists that, if not addressed, may result in injury or harm to the member or to other persons or in significant amounts of property damage.

“HCBS” means home- and community-based services.

“Individual employment” means employment in the general workforce where the member interacts with the general public to the same degree as nondisabled persons in the same job, and for which the member is paid at or above minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by persons without disabilities.

“Individual placement and support” or *“IPS”* means the evidence-based practice of supported employment that is guided by IPS practice principles outlined by the IPS Employment Center at Westat as amended to July 1, 2026, and as measured by its employment fidelity scale available online at ipsworks.org as amended to July 1, 2026.

“Integrated community employment” means work (including self-employment) for which an individual with a disability is paid at or above minimum wage and not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by employees who are not disabled, where the individual interacts with other persons who are not disabled to the same extent as others who are in comparable positions, and that presents opportunities for advancement that are similar to those for employees who are not disabled. In the case of an individual who is self-employed, the business results in an income that is comparable to the income received by others who are not disabled and are self-employed in similar occupations.

“Intensive residential service homes” or *“intensive residential services”* means intensive, community-based services provided 24 hours per day, 7 days per week, 365 days per year to individuals with a severe and persistent mental illness who have functional impairments and may also have multi-occurring conditions. Providers of intensive residential service homes are enrolled with Medicaid as providers of HCBS habilitation, home-based habilitation, or HCBS intellectual disability waiver supported community living and meet additional criteria specified in rule 441—77.30(249A) and the provider manual as amended to July 1, 2026.

“Interdisciplinary team” means a group of persons with varied professional backgrounds who meet with the member to develop a comprehensive service plan to address the member’s need for services.

“IoWANS” means the department’s Institutional and Waiver Authorization and Narrative System.

“Level of Care Utilization System” or *“LOCUS”* means the comprehensive functional assessment tool utilized to determine eligibility for the habilitation program and service authorization for the home-based habilitation and intensive residential services for individuals aged 19 and older.

“Managed care organization” or *“MCO”* means an entity that (1) is under contract with the department to provide services to Medicaid recipients and (2) meets the definition of “health maintenance organization” as defined in Iowa Code section 514B.1.

“Member” means a person who has been determined to be eligible for Medicaid under 441—Chapter 75.

“Program” means a set of related resources and services directed to the accomplishment of a fixed set of goals for qualifying members.

“Severe and persistent mental illness” or *“SPMI”* means a documented primary mental health disorder diagnosed by a mental health professional that causes symptoms and impairments in basic mental and behavioral processes that produce distress and major functional disability in adult role functioning inclusive of social, personal, family, educational, or vocational roles.

“Supported employment” means the ongoing supports to participants who, because of their disabilities, need intensive ongoing support to obtain and maintain an individual job in competitive or customized employment, or self-employment, in an integrated work setting in the general workforce at or above the state’s minimum wage or at or above the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. The outcome of this service is sustained paid employment at or above the minimum wage in an integrated setting in the general workforce in a job that meets personal and career goals. Supported employment services can be provided through many different service models.

“Supported self-employment” includes services and supports that assist the participant in achieving self-employment through the operation of a business; however, Medicaid funds may not be used to defray the expenses associated with starting up or operating a business. Assistance for self-employment may include aid to the individual in identifying potential business opportunities; assistance in the development of a business plan, including potential sources of business financing and other assistance in developing and launching a business; identification of the supports necessary for the individual to operate the business; and ongoing assistance, counseling and guidance once the business has been launched.

“Sustained employment” means an individual employment situation that the member maintains over time but not for less than 90 calendar days following the receipt of employment services and supports.

78.27(2) Member eligibility. To be eligible to receive home- and community-based habilitation services, a member shall meet the following criteria.

a. LOCUS/CALOCUS actual disposition. The member has a LOCUS/CALOCUS actual disposition of level one recovery maintenance and health management or higher on the most current LOCUS/CALOCUS assessment completed within the past 30 days.

b. Risk factors. The member meets at least one of the following risk-based criteria:

(1) The member has a history of inpatient, partial hospitalization, or emergency psychiatric treatment more than once in the member’s life; or

(2) The member has a history of continuous professional psychiatric supportive care other than hospitalization; or

(3) The member has a history of involvement with the criminal justice system; or

(4) Services available in the member’s community have not been able to meet the member’s needs; or

(5) The member has a history of unemployment or employment in a sheltered setting or poor work history; or

(6) The member has a history of homelessness or is at risk of homelessness.

c. Need for assistance. The member has a need for assistance demonstrated by meeting at least two of the following criteria on a continuing or intermittent basis for at least 12 months:

- (1) The member needs assistance to obtain or maintain employment.
- (2) The member requires financial assistance to reside independently in the community.
- (3) The member needs significant assistance to establish or maintain a personal social support system.
- (4) The member needs assistance with at least one of the activities of daily living (ADLs) or instrumental activities of daily living (IADLs) to reside independently in the community.
- (5) The member needs assistance with management and intervention of maladaptive or antisocial behaviors to ensure the safety of the individual or others.

d. Income. The countable income used in determining the member's Medicaid eligibility does not exceed 150 percent of the federal poverty level.

e. Needs assessment. The department-approved assessment tool has been completed, and Iowa Medicaid has determined that the member is in need of home- and community-based habilitation services.

f. Designated case manager. The designated case manager shall:

- (1) Arrange for the completion of the needs-based assessment before services begin, and annually thereafter, and more frequently if significant observable changes occur in the member's situation, condition, or circumstances.
- (2) Use the information submission tool and other supporting documentation as relevant to develop a comprehensive service plan as specified in subrule 78.27(4) and 441—paragraph 90.4(1) “b” before services begin and annually thereafter, and when there is a significant observable change in the member's situation, condition, or circumstances.

g. Plan for service. The department or the member's MCO has approved the member's comprehensive service plan for home- and community-based habilitation services. Home- and community-based habilitation services included in a comprehensive service plan or treatment plan that has been validated by Iowa Medicaid or the member's MCO will be considered approved by the department. Home- and community-based habilitation services provided before approval of a member's eligibility for the program cannot be reimbursed.

(1) The member's comprehensive service plan shall be completed annually according to the requirements of subrule 78.27(4) and 441—paragraph 90.4(1) “b.” A service plan may change when requested by the member or the member's interdisciplinary team when there is a significant observable change in the member's situation, condition, or circumstances.

(2) For members receiving home-based habilitation, the service plan shall include the member's needs-based assessment, actual disposition, the composite score, and each individual domain score for each of the six assessed domains.

(3) The member's habilitation services shall not exceed the maximum number of units established for each service in 441—subrule 79.1(2).

(4) The cost of the habilitation services shall not exceed unit expense maximums established in 441—subrule 79.1(2).

78.27(3) Application for services. The member or case manager shall apply for habilitation services on behalf of a member by contacting Iowa Medicaid. The department will issue a notice of decision to the applicant in accordance with 441—Chapter 16 when financial eligibility and needs-based eligibility determinations have been completed.

78.27(4) Comprehensive service plan. Individualized, planned, and appropriate services shall be guided by a member-specific comprehensive service plan or treatment plan developed with the member in collaboration with an interdisciplinary team, as appropriate. Medically necessary services shall be planned for and provided at the locations where the member lives, learns, works, and socializes.

a. Development. A comprehensive service plan or treatment plan shall be developed for each member receiving home- and community-based habilitation services based on the member's current

assessment and shall be reviewed on an annual basis. The comprehensive service plan will meet the criteria described in the HCBS habilitation manual.

b. Rights restrictions. Any rights restrictions must be implemented in accordance with 441—subrule 77.30(4).

c. Emergency plan. The comprehensive service plan or treatment plan shall include a plan for emergencies and identification of the supports available to the member in an emergency. Emergency plans shall be developed as detailed in the HCBS habilitation manual.

d. Plan approval. Services shall be entered into IoWANS based on the comprehensive service plan. A comprehensive service plan or treatment plan that has been validated and authorized through IoWANS will be considered approved by the department. Services must be authorized in IoWANS as specified in paragraph 78.27(2)“g.”

78.27(5) Requirements for services. Home- and community-based habilitation services shall be provided in accordance with the following requirements:

a. The services shall be based on the member’s needs as identified in the member’s comprehensive service plan.

b. The services shall be delivered in the least restrictive environment appropriate to the needs of the member.

c. The services shall include the applicable and necessary instruction, supervision, assistance, and support required by the member to achieve the member’s life goals.

d. Service components that are the same or similar shall not be provided simultaneously.

e. Service costs are not reimbursable while the member is in a medical institution, including but not limited to a hospital or nursing facility.

f. Reimbursement is not available for room and board.

g. Services shall be billed in whole units.

h. Services shall be documented. Each unit billed must have corresponding financial and medical records as set forth in rule 441—79.3(249A).

78.27(6) Case management. Case management assists members in gaining access to needed medical, social, educational, housing, transportation, vocational, and other appropriate services in order to ensure the health, safety, and welfare of the member.

a. Scope. Case management services shall be provided as set forth in rules 441—90.4(249A) through 441—90.7(249A).

b. Exclusions. Payment will not be made for case management provided to a member who is eligible for targeted case management services under 441—Chapter 90.

78.27(7) Home-based habilitation. “Home-based habilitation” means individually tailored supports that assist with the acquisition, retention, or improvement of skills related to living, working, and recreating in the community.

a. Scope. Home-based habilitation services are individualized supportive services provided in the member’s home and community that assist the member to reside in the most integrated setting appropriate to the member’s needs. Services are intended to provide for the daily living needs of the member and shall be available as needed during any 24-hour period. The specific support needs for each member shall be determined necessary by the interdisciplinary team and shall be identified in the member’s comprehensive service plan. Covered supports include:

- (1) Adaptive skill development;
- (2) Assistance with activities to address daily living needs;
- (3) Assistance with symptom management and participation in mental health treatment;
- (4) Assistance with accessing physical and mental health care treatment, communication, and implementation of health care recommendations and treatment;
- (5) Assistance with accessing and participating in substance use disorder treatment and services;
- (6) Assistance with medication administration and medication management;
- (7) Assistance with understanding communication whether verbal or written;
- (8) Community inclusion and active participation in the community;

- (9) Transportation;
- (10) Adult educational supports, which may include assistance and support with enrolling in educational opportunities and participation in education and training;
- (11) Social and leisure skill development;
- (12) Personal care; and
- (13) Protective oversight and supervision.

b. Setting requirements. Home-based habilitation services shall occur in the member's home and community.

(1) A member may live in the member's own home, within the home of the member's family or legal representative, or in another community living arrangement that meets the criteria in 441—subrule 77.30(5).

(2) A member living with the member's family or legal representative is not subject to the criteria in 441—paragraphs 77.30(7) “d” and “e.”

(3) A member may not reside in a licensed medical or health care facility or in a setting that is required to be licensed as a medical or health care facility.

c. Home-based habilitation level of service criteria. Home-based habilitation services shall be available to members based on the member's most current LOCUS/CALOCUS actual disposition score, according to the following criteria:

(1) Intensive IV residential habilitation services. Intensive IV services are provided 24 hours per day. To be eligible for intensive IV services, a member must meet the following criteria:

1. The member has a LOCUS/CALOCUS actual disposition of level six medically managed residential services, and

2. The member is in need of 24-hour supervised and monitored treatment to maintain or improve functioning and avoid relapse that would require a higher level of treatment;

(2) Intensive III services are provided 17 to 24 hours per day. To be eligible for intensive III services, the member must have a LOCUS/CALOCUS actual disposition of level five.

(3) Intensive II services are provided 13 to 16.75 hours per day. To be eligible for intensive II services, the member must have a LOCUS/CALOCUS actual disposition of level four.

(4) Intensive I services are provided 9 to 12.75 hours per day. To be eligible for intensive I services, the member must have a LOCUS/CALOCUS actual disposition of level three.

(5) Medium need services are provided 4.25 to 8.75 hours per day as needed. To be eligible for medium need services, the member must have a LOCUS/CALOCUS actual disposition of level two.

(6) Recovery transitional services are provided 2.25 to 4 hours per day as needed. To be eligible for recovery transitional services, the member must have a LOCUS/CALOCUS actual disposition of level one.

(7) High recovery services are provided 0.25 to 2 hours per day as needed. To be eligible for high recovery services, the member must have a LOCUS/CALOCUS actual disposition of level one.

d. Additional criteria for receiving home-based habilitation services for transition-age youth 16 to 18 years of age.

(1) Members residing in the family home may receive home-based habilitation services as needed, subject to the criteria set forth in this rule.

(2) Individuals 16 to 18 years of age shall receive 24-hour site supervision and support.

(3) Members residing outside of the family home may receive daily home-based habilitation in a provider-owned or controlled setting when the following criteria are met:

1. The proposed living environment must meet HCBS setting requirements in accordance with 441—subrule 77.30(5).

2. All providers of the service setting being requested must meet the following additional safety and service requirements for serving youth under the age of 18:

- Individuals under the age of 18 may not reside in settings with individuals over the age of 21.

- The comprehensive service plan shall specifically identify educational services and supports for individuals who have not obtained a high school diploma or equivalent.

- For individuals who have obtained a high school diploma or equivalent, the comprehensive service plan shall include supported employment, additional training, or educational supports.

- (4) The member's parent or guardian has consented to home-based habilitation services.

- (5) The member is able to pay room and board costs (funding sources may include but are not limited to supplemental security income, child support, adoptions subsidy, or private funds).

- (6) Youth under the age of 16 needing daily home-based habilitation outside the family home must receive services in a licensed or certified residential-based supported community living setting.

- e. Exclusions.* Home-based habilitation payment will not be made for the following:

- (1) Room and board and maintenance costs, including the cost of rent or mortgage, utilities, telephone, food, household supplies, and building maintenance, upkeep, or improvement.

- (2) Service activities associated with vocational services, day care, medical services, or case management.

- (3) Transportation to and from a day program.

- (4) Services provided to a member who lives in a licensed residential care facility of more than 16 persons.

- (5) Services provided to a member who lives in a facility that provides the same service as part of an inclusive or "bundled" service rate, such as a nursing facility or an ICF/ID.

- (6) Personal care and protective oversight and supervision may be a component part of home-based habilitation services but may not comprise the entirety of the service.

78.27(8) Day habilitation. "Day habilitation" means services that provide opportunities and support for community inclusion and build interest in and develop skills for active participation in recreation, volunteerism and integrated community employment. Day habilitation provides assistance with acquisition, retention, or improvement of socialization, community participation, and daily living skills.

- a. Scope.* Day habilitation activities and environments are designed to foster the acquisition of skills, positive social behavior, greater independence, and personal choice. Services focus on supporting the member to participate in the community, develop social roles and relationships, and increase independence and the potential for employment. Services are designed to assist the member to attain or maintain the member's individual goals as identified in the member's comprehensive service plan. Services may also provide wraparound support secondary to community employment. Day habilitation activities may include:

- (1) Identifying the member's interests, preferences, skills, strengths and contributions,

- (2) Identifying the conditions and supports necessary for full community inclusion and the potential for competitive integrated employment,

- (3) Planning and coordination of the member's individualized daily and weekly day habilitation schedule,

- (4) Developing skills and competencies necessary to pursue competitive integrated employment,

- (5) Participating in community activities related to hobbies, leisure, personal health, and wellness,

- (6) Participating in community activities related to cultural, civic, and religious interests,

- (7) Participating in adult learning opportunities,

- (8) Participating in volunteer opportunities,

- (9) Training and education in self-advocacy and self-determination to support the member's ability to make informed choices about where to live, work, and recreate,

- (10) Assistance with behavior management and self-regulation,

- (11) Use of transportation and other community resources,

- (12) Assistance with developing and maintaining natural relationships in the community,

- (13) Assistance with identifying and using natural supports,

- (14) Assistance with accessing financial literacy and benefits education,

(15) Other activities deemed necessary to assist the member with full participation in the community, developing social roles and relationships, and increasing independence and the potential for employment.

b. Family training option. Day habilitation services may include training families in treatment and support methodologies or in the care and use of equipment. Family training may be provided in the member's home. The unit of service is 15 minutes. The units of services payable are limited to a maximum of 40 units per month.

c. Expected outcome of service. The expected outcome of day habilitation services is active participation in the community in which the member lives, works, and recreates. Members are expected to have opportunities to interact with individuals without disabilities in the community, other than those providing direct services, to the same extent as individuals without disabilities.

d. Setting. Day habilitation shall take place in community-based, nonresidential settings separate from the member's residence. Family training may be provided in the member's home.

e. Duration. Day habilitation services shall be furnished as specified in the member's comprehensive service plan. Meals provided as part of day habilitation shall not constitute a full nutritional regimen (three meals per day).

f. Unit of service. A unit of day habilitation is 15 minutes (up to 16 units per day) or a full day (4.25 to 8 hours).

g. Concurrent services. A member's comprehensive service plan may include two or more types of nonresidential habilitation services (e.g., day habilitation, individual supported employment, long-term job coaching, small-group supported employment, and prevocational services). However, more than one service may not be billed during the same period of time (e.g., the same hour).

h. Transportation. When transportation is provided to the day habilitation service location from the member's home and from the day habilitation service location to the member's home, the day habilitation provider may bill for the time spent transporting the member.

i. Exclusions. Day habilitation payment will not be made for the following:

(1) Services that are available to the individual under a program funded under Section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq. as amended to July 1, 2026). Documentation that funding is not available to the individual for the service under these programs shall be maintained in the service plan of each member receiving day habilitation services.

(2) Compensation to members for participating in day habilitation.

(3) Support for members volunteering in for-profit organizations and businesses.

(4) Support for members volunteering to benefit the day habilitation service provider.

78.27(9) Prevocational service habilitation. "Prevocational services" means services that provide career exploration, learning and work experiences, including volunteer opportunities, where the member can develop non-job-task-specific strengths and skills that lead to paid employment in individual community settings.

a. Scope. Prevocational services are provided to persons who are expected to be able to join the general workforce with the assistance of supported employment. Prevocational services are intended to develop and teach general employability skills relevant to successful participation in individual employment. These skills include but are not limited to the ability to communicate effectively with supervisors, coworkers and customers; an understanding of generally accepted community workplace conduct and dress; the ability to follow directions; the ability to attend to tasks; workplace problem-solving skills and strategies; general workplace safety and mobility training; the ability to navigate local transportation options; financial literacy skills; and skills related to obtaining employment.

Prevocational services include career exploration activities to facilitate successful transition to individual employment in the community. Participation in prevocational services is not a prerequisite for individual or small-group supported employment services.

(1) Career exploration. Career exploration activities are designed to develop an individual career plan and facilitate the member's experientially based informed choice regarding the goal of individual

employment. Career exploration may be provided in small groups of no more than four members to participate in career exploration activities that include business tours, attending industry education events, benefit information, financial literacy classes, and attending career fairs. Career exploration may be authorized for up to 34 hours, to be completed over 90 days in the member's local community or nearby communities and may include but is not limited to the following activities:

1. Meeting with the member and the member's family, guardian or legal representative to introduce them to supported employment and explore the member's employment goals and experiences,

2. Business tours,
3. Informational interviews,
4. Job shadows,
5. Benefits education and financial literacy,
6. Assistive technology assessment, and
7. Job exploration events.

- (2) Expected outcome of service.

1. The expected outcome of prevocational services is individual employment in the general workforce, or self-employment, in a setting typically found in the community, where the member interacts with individuals without disabilities, other than those providing services to the member or other individuals with disabilities, to the same extent that individuals without disabilities in comparable positions interact with other persons; and for which the member is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities.

2. The expected outcome of the career exploration activity is a written career plan that will guide employment services that lead to community employment or self-employment for the member.

- b. Setting.* Prevocational services shall take place in community-based nonresidential settings.

- c. Concurrent services.* A member's individual service plan may include two or more types of nonresidential habilitation services (e.g., individual supported employment, long-term job coaching, small-group supported employment, prevocational services, and day habilitation); however, more than one service may not be billed during the same period of time (e.g., the same hour).

- d. Exclusions.* Prevocational services payment shall not be made for the following:

- (1) Services that are available to the individual under a program funded under Section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq. as amended to July 1, 2026). Documentation that funding is not available to the individual for the service under these programs shall be maintained in the service plan of each member receiving prevocational services.

- (2) Services available to the individual that duplicate or replace education or related services defined in the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq. as amended to July 1, 2026).

- (3) Compensation to members for participating in prevocational services.

- (4) Support for members volunteering in for-profit organizations and businesses other than for-profit organizations, or businesses that have formal volunteer programs in place (e.g., hospitals, nursing homes), and support for members volunteering to benefit the service provider.

- (5) The provision of vocational services delivered in facility-based settings where individuals are supervised for the primary purpose of producing goods or performing services or where services are aimed at teaching skills for specific types of jobs rather than general skills.

- (6) A prevocational service plan with the goal or purpose of the service documented as maintaining or supporting the individual in continuing prevocational services or any employment situation similar to sheltered employment.

- e. Limitations.*

(1) Time limitation for members starting prevocational services. For members starting prevocational services, participation in these services is limited to 24 calendar months. This time limit can be extended to continue beyond 24 months if one or more of the following conditions apply:

1. The member who is in prevocational services is also working in either individual or small-group community employment for at least the number of hours per week desired by the member, as identified in the member's current service plan; or

2. The member who is in prevocational services is also working in either individual or small-group community employment for less than the number of hours per week the member desires, as identified in the member's current service plan, but the member has services documented in the member's current service plan, or through another identifiable funding source (e.g., Iowa vocational rehabilitation services (IVRS)), to increase the number of hours the member is working in either individual or small-group community employment; or

3. The member is actively engaged in seeking individual or small-group community employment or individual self-employment, and services for this are included in the member's current service plan or services funded through another identifiable funding source (e.g., IVRS) are documented in the member's service plan; or

4. The member has requested supported employment services from Medicaid and IVRS in the past 24 months, and the member's request has been denied or the member has been placed on a waiting list by both Medicaid and IVRS; or

5. The member has been receiving individual supported employment services (or comparable services available through IVRS) for at least 18 months without obtaining individual or small-group community employment or individual self-employment; or

6. The member is participating in career exploration activities as described in subparagraph 78.27(9)"a"(1).

(2) Time limitation for members enrolled in prevocational services. For members enrolled in prevocational services, participation in these services is limited to 90 business days beyond the completion of the career exploration activity including the development of the career plan described in subparagraph 78.27(9)"a"(1). This time limit can be extended as stated in numbered paragraphs 78.27(9)"e"(1)"1" through "6." If the criteria in numbered paragraphs 78.27(9)"e"(1)"1" through "6" do not apply, the member will not be reauthorized to continue prevocational services.

78.27(10) *Supported employment services.*

a. Individual supported employment. Individual supported employment involves supports provided to, or on behalf of, the member that enable the member to obtain and maintain individual employment. Services are provided to members who need support because of their disabilities.

- (1) Scope. Individual supported employment services are services provided to, or on behalf of, the member that enable the member to obtain and maintain an individual job in competitive employment, customized employment or self-employment in an integrated work setting in the general workforce.

- (2) Expected outcome of service. The expected outcome of this service is sustained employment, or self-employment, paid at or above the minimum wage or the customary wage and level of benefits paid by an employer, in an integrated setting in the general workforce, in a job that meets personal and career goals. Successful transition to long-term job coaching, if needed, is also an expected outcome of this service. An expected outcome of supported self-employment is that the member earns income that is equal to or exceeds the average income for the chosen business within a reasonable period of time.

- (3) Setting. Individual supported employment services shall take place in integrated work settings. For self-employment, the member's home can be considered an integrated work setting. Employment in the service provider's organization (not including a sheltered workshop or similar type of work setting where members are paid for the production of goods or services) can be considered employment in an integrated work setting in the general workforce if the employment occurs in a

work setting where interactions are predominantly with coworkers or business associates who do not have disabilities or with the general public.

(4) Individual employment strategies include but are not limited to customized employment, individual placement and support, and supported self-employment. Service activities are individualized and may include any combination of the following:

1. Benefits education.
2. Career exploration (e.g., tours, informational interviews, job shadows).
3. Employment assessment.
4. Assistive technology assessment.
5. Trial work experience.
6. Person-centered employment planning.
7. Development of visual/traditional résumés.
8. Job-seeking skills training and support.
9. Outreach to prospective employers on behalf of the member (e.g., job development; negotiation with prospective employers to customize, create or carve out a position for the member; employer needs analysis).
10. Job analysis (e.g., work site assessment or job accommodations evaluation).
11. Identifying and arranging transportation.
12. Career advancement services (e.g., assisting a member in making an upward career move or seeking promotion from an existing employer).
13. Reemployment services (if necessary due to job loss).
14. Financial literacy and asset development.
15. Other employment support services deemed necessary to enable the member to obtain employment.
16. Systematic instruction and support during initial on-the-job training including initial on-the-job training to stabilization.
17. Engagement of natural supports during initial period of employment.
18. Implementation of assistive technology solutions during initial period of employment.
19. Transportation of the member during service hours.
20. Initial on-the-job training to stabilization activity.

(5) Self-employment. Individual employment may also include support to establish a viable self-employment opportunity, including home-based self-employment. An expected outcome of supported self-employment is that the member earns income that is equal to or exceeds the average income for the chosen business within a reasonable period of time. In addition to the activities listed under subparagraph 78.27(10) "a"(4), assistance to establish self-employment may include:

1. Aid to the member in identifying potential business opportunities.
2. Assistance in the development of a business plan, including identifying potential sources of business financing and other assistance in developing and launching a business.
3. Identification of the long-term supports necessary for the individual to operate the business.
- b. Long-term job coaching.* Long-term job coaching is support provided to, or on behalf of, the member that enables the member to maintain an individual job in competitive employment, customized employment or self-employment in an integrated work setting in the general workforce.

(1) Scope. Long-term job coaching services are provided to or on behalf of members who need support because of their disabilities and who are unlikely to maintain and advance in individual employment absent the provision of supports. Long-term job coaching services shall provide individualized and ongoing support contacts at intervals necessary to promote successful job retention and advancement.

(2) Expected outcome of service. The expected outcome of this service is sustained employment paid at or above the minimum wage in an integrated setting in the general workforce, in a job that meets the member's personal and career goals. An expected outcome of supported self-employment is

that the member earns income that is equal to or exceeds the average income for the chosen business within a reasonable period of time.

(3) **Setting.** Long-term job coaching services shall take place in integrated work settings. For self-employment, the member's home can be considered an integrated work setting. Employment in the service provider's organization (not including a sheltered workshop or similar type of work setting) can be considered employment in an integrated work setting in the general workforce if the employment occurs in a work setting where interactions are predominantly with coworkers or business associates who do not have disabilities, or with the general public, and if the position would exist within the provider's organization were the provider not being paid to provide the job coaching to the member.

(4) **Service activities.** Long-term job coaching services are designed to assist the member with learning and retaining individual employment, resulting in workplace integration, which allows the reduction of long-term job coaching over time. Services are individualized, and service plans are adjusted as support needs change and may include any combination of the following activities with or on behalf of the member:

1. Job analysis.
2. Job training and systematic instruction.
3. Training and support for use of assistive technology/adaptive aids.
4. Engagement of natural supports.
5. Transportation coordination.
6. Job retention training and support.
7. Benefits education and ongoing support.
8. Supports for career advancement.
9. Financial literacy and asset development.
10. Employer consultation and support.
11. Negotiation with employer on behalf of the member (e.g., accommodations; employment conditions; access to natural supports; and wage and benefits).
12. Other workplace support services may include services not specifically related to job skill training that enable the waiver member to be successful in integrating into the job setting.
13. Transportation of the member during service hours.
14. Career exploration services leading to increased hours or career advancement.

(5) **Self-employment long-term job coaching.** Self-employment long-term job coaching may include support to maintain a self-employment opportunity, including home-based self-employment. In addition to the activities listed under subparagraph 78.27(10) "b"(4), assistance to maintain self-employment may include:

1. Ongoing identification of the supports necessary for the individual to operate the business;
2. Ongoing assistance, counseling and guidance to maintain and grow the business; and
3. Ongoing benefits education and support.

(6) The hours of support for long-term job coaching are based on the identified needs of the member as documented in the member's comprehensive service plan.

c. Small-group supported employment. Small-group supported employment services are training and support activities provided in regular business or industry settings for groups of two to eight workers with disabilities. The outcome of this service is sustained paid employment experience, skill development, career exploration and planning leading to referral for services to obtain individual integrated employment or self-employment for which an individual is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities.

(1) **Scope.** Small-group supported employment services must be provided in a manner that promotes integration into the workplace and interaction between members and people without disabilities (e.g., customers, coworkers, natural supports) in those workplaces. Examples include but are not limited to mobile crews and other business-based workgroups employing small groups of

workers with disabilities in employment in integrated business settings; and small-group activities focused on career exploration and development of strengths and skills that contribute to successful participation in individual community employment.

(2) Expected outcome of service. Small-group supported employment services are expected to enable the member to make reasonable and continued progress toward individual employment. Participation in small-group supported employment services is not a prerequisite for individual supported employment services. The expected outcome of the service is sustained paid employment and skill development that leads to individual employment in the community.

(3) Setting. Small-group supported employment services shall take place in integrated, community-based nonresidential settings separate from the member's residence.

(4) Service activities. Small-group supported employment services may include any combination of the following activities:

1. Employment assessment.
 2. Person-centered employment planning.
 3. Job placement (limited to service necessary to facilitate hire into individual employment paid at minimum wage or higher for a member in small-group supported employment who receives an otherwise unsolicited offer of a job from a business where the member has been working in a mobile crew or enclave).
 4. Job analysis.
 5. On-the-job training and systematic instruction.
 6. Job coaching.
 7. Transportation planning and training.
 8. Benefits education.
 9. Career exploration services leading to career advancement outcomes.
 10. Other workplace support services may include services not specifically related to job skill training that enable the waiver member to be successful in integrating into the individual or community setting.
 11. Transportation of the member during service hours.
- d. Individual placement and support (IPS).*

(1) IPS shall include the following activities, which shall be described and documented in the member's employment plan:

1. Development of the career profile, including previous work experience, goals, preferences, strengths, barriers, skills, disclosure preferences, career advancement, education and plan for graduation.
2. Integration of IPS team members and the behavioral health team, including routine staffing meetings regarding IPS clients.
3. Addressing barriers to employment, which may be actual or perceived. Support may include addressing justice system involvement, a lack of work history, limited housing, child care, and transportation.
4. Rapid job search and systematic job development. Community and employment supports (CESs) help members seek jobs directly and do not provide extensive preemployment assessment and training or intermediate work experiences. The job process begins within 30 days of starting IPS services. This rapid job search is supported by CESs developing relationships with employers through multiple face-to-face meetings. CESs take time to learn about the employers' needs and the work environment while gathering information about job opportunities that might be a good fit for individuals they are working with.
5. Disclosure counseling, to assist the member in making an informed decision on disclosure of a disability to a prospective or current employer.
6. Identification and implementation of job accommodations and assistive technology supports.

7. Ongoing benefits counseling. The member must receive information on available work incentive programs, or referral to professional benefits counselors for a personalized work incentives plan for any state or federal entitlement.

8. Time-unlimited follow-along supports. These supports are planned for early in the employment process, are personalized, and follow the member for as long as the member needs support. The focus is supporting the member in becoming as independent as possible and involving family members, co-workers, and other natural supports. These supports can be provided on or off the job site and focus on the continued acquisition and development of skills needed to maintain employment.

(2) Units of service. Reimbursement is made for each outcome achieved for the member participating in the IPS supported employment model. Outcomes are as follows:

1. Outcome #1: Completed employment plan.
2. Outcome #2: First day of successful job placement.
3. Outcome #3: 45 days successful job retention.
4. Outcome #4: 90 days successful job retention.
- e. *Service requirements for all supported employment services.*

(1) Community transportation options (e.g., transportation provided by family, coworkers, carpools, volunteers, self or public transportation) shall be identified by the member's interdisciplinary team and utilized before the service provider provides the transportation to and from work for the member. If none of these options are available to a member, transportation between the member's place of residence and the employment or service location may be included as a component part of supported employment services.

(2) Personal care or personal assistance and protective oversight may be a component part of supported employment services, but may not comprise the entirety of the service.

(3) Activities performed on behalf of a member receiving long-term job coaching or individual or small-group supported employment shall not comprise the entirety of the service.

(4) Concurrent services. A member's individual service plan may include two or more types of nonresidential services (e.g., individual supported employment, long-term job coaching, small-group supported employment, prevocational services, and day habilitation); however, more than one service may not be billed during the same period of time (e.g., the same hour).

(5) Integration requirements. In the performance of job duties, the member shall have regular contact with other employees or members of the general public who do not have disabilities, unless the absence of regular contact with other employees or the general public is typical for the job as performed by persons without disabilities.

(6) Compensation. Members receiving these services are compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. For supported self-employment, the member earns income that is equal to or exceeds the average income for the chosen business within a reasonable period of time. For small-group supported employment, if the member is not compensated at or above minimum wage, the compensation to the member shall be in accordance with all applicable state and federal labor laws and regulations.

f. *Limitations.* Supported employment services are limited as follows:

(1) Total monthly costs of supported employment may not exceed the monthly cap on the cost of waiver services set for the individual waiver program.

(2) In absence of a monthly cap on the cost of waiver services, the total monthly cost of all supported employment services may not exceed the cost limitations published on the Iowa Medicaid fee schedule webpage.

(3) Individual supported employment is limited to 60 hourly units per calendar year.

(4) Long-term job coaching is limited in accordance with 441—subrule 79.1(2).

(5) Small-group supported employment is limited to 160 units per week.

g. *Exclusions.* Supported employment services payments will not be made for the following:

(1) Services that are available to the individual under a program funded under Section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq. as amended to July 1, 2026). Documentation that the service is not available to the individual under these programs shall be maintained in the service plan of each member receiving individual supported employment or long-term job coaching services.

(2) Incentive payments, not including payments for coworker supports, made to an employer to encourage or subsidize the employer's participation in a supported employment program.

(3) Subsidies or payments that are passed through to users of supported employment programs.

(4) Training that is not directly related to a member's supported employment program.

(5) Services involved in placing and stabilizing members in day activity programs, work activity programs, sheltered workshop programs or other similar types of vocational or prevocational services furnished in specialized facilities that are not a part of the general workplace.

(6) Supports for placement and stabilization in volunteer positions or unpaid internships. Such volunteer learning and unpaid training activities that prepare a person for entry into the general workforce are addressed through prevocational services and career exploration activities.

(7) Tuition for education or vocational training.

(8) Individual advocacy that is not related to integrated individual employment participation or is not member-specific.

(9) Medicaid funds may not be used to defray the expenses associated with starting up or operating a business.

78.27(11) *Adverse service actions.*

a. Denial. Services will be denied when the department determines that:

(1) The member is not eligible for or in need of home- and community-based habilitation services.

(2) The service is not identified in the member's comprehensive service plan or treatment plan.

(3) Needed services are not available or received from qualifying providers, or no qualifying providers are available.

(4) The member's service needs exceed the unit or reimbursement maximums for a service as set forth in 441—subrule 79.1(2).

(5) Completion or receipt of required documents for the program has not occurred.

b. Reduction. A particular home- and community-based habilitation service may be reduced when the department determines that continued provision of service at its current level is not necessary.

c. Termination. A particular home- and community-based habilitation service may be terminated when the department determines that:

(1) The member's income exceeds the allowable limit, or the member no longer meets other eligibility criteria for the program established by the department.

(2) The service is not identified in the member's comprehensive service plan.

(3) Needed services are not available or received from qualifying providers, or no qualifying providers are available.

(4) The member's service needs are not being met by the services provided.

(5) The member has received care in a medical institution for 120 consecutive days in any one stay. When a member has been an inpatient in a medical institution for 120 consecutive days, the department will issue a notice of decision pursuant to 441—Chapter 16 to inform the member of the service termination. If the member returns home before the effective date of the notice of decision and the member's condition has not substantially changed, the decision will be rescinded, and eligibility for home- and community-based habilitation services shall continue.

(6) The member's service needs exceed the unit or reimbursement maximums for a service as established by the department.

(7) Duplication of services provided during the same period has occurred.

(8) The member or the member's legal representative, through the interdisciplinary process, requests termination of the service.

(9) Completion or receipt of required documents for the program has not occurred, or the member refuses to allow documentation of eligibility as to need and income.

d. Appeal rights. The department shall give notice of any adverse action pursuant to 441—Chapter 16 and the right to appeal in accordance with 441—Chapter 2506. The member is entitled to have a review of the determination of needs-based eligibility or of the actual disposition score by sending a letter requesting a review to Iowa Medicaid at the department's address. If dissatisfied with that decision, the member may file an appeal with the department.

[ARC 0315D, IAB 5/27/26, effective 7/1/26]

441—78.28(249A) List of medical services and equipment requiring prior authorization, preprocedure review or preadmission review.

78.28(1) Services, procedures, and medications prescribed by a physician, PA, or ARNP that are subject to prior authorization or preprocedure review are as follows or as specified in the preferred drug list published by the department pursuant to Iowa Code section 249A.20A:

a. Drugs require prior authorization as specified in the preferred drug list published by the department pursuant to Iowa Code section 249A.20A. For drugs requiring prior authorization, reimbursement will be made for a 72-hour supply dispensed in an emergency when a prior authorization request cannot be submitted.

b. Reserved.

c. Enteral products and enteral delivery pumps and supplies. Payment will be approved pursuant to the criteria in subrule 78.10(5).

d. Reserved.

e. Speech generating device. Payment will be approved pursuant to the criteria in subrule 78.10(5).

f. Preprocedure review by Iowa Medicaid will be required if payment under Medicaid is to be made for certain frequently performed surgical procedures that have a wide variation in the relative frequency the procedures are performed. Preprocedure surgical review applies to surgeries performed in hospitals (outpatient and inpatient) and ambulatory surgical centers. Approval by Iowa Medicaid will be granted only if the procedures are determined to be medically necessary based on the condition of the patient and on the criteria established by the department. If not approved by Iowa Medicaid, payment will not be made under the program to the physician or to the facility in which the surgery is performed. The criteria are available from Iowa Medicaid.

g. Enclosed beds. Payment will be approved pursuant to the criteria in subrule 78.10(5).

h. Prior authorization is required for external insulin infusion pumps and is granted according to Medicare coverage criteria.

i. Oral nutritional products. Payment will be approved pursuant to the criteria in subrule 78.10(5).

j. Vest airway clearance system. Payment will be approved pursuant to the criteria in subrule 78.10(5).

k. DME rebate agreements. Payment will be approved pursuant to the criteria in subrule 78.10(5).

l. Reimbursement over the established Medicaid fee schedule amount. Payment will be approved pursuant to the criteria in subrule 78.10(5).

m. Bathtub/shower chair, bench. Payment will be approved pursuant to the criteria in subrule 78.10(5).

n. Patient lift, nonstandard. Payment will be approved pursuant to the criteria in subrule 78.10(5).

o. Power wheelchair attendant control. Payment will be approved pursuant to the criteria in subrule 78.10(5).

p. Shower commode chair. Payment will be approved pursuant to the criteria in subrule 78.10(5).

q. Ventilator, secondary. Payment will be approved pursuant to the Medicare coverage criteria.

r. Customized wheelchairs, subject to the requirements of paragraph 78.10(2) “*d.*”

78.28(2) Notwithstanding the provisions of paragraph 78.28(1) “*a.*,” under both Medicaid fee-for-service and managed care administration, at least one form of each of the following drugs for medication-assisted treatment as approved by the United States Food and Drug Administration for treatment of substance use disorder or overdose treatment will be available without prior authorization:

a. Buprenorphine,

b. Buprenorphine and naloxone combination,

c. Methadone,

d. Naltrexone, and

e. Naloxone.

For the purpose of this subrule, “medication-assisted treatment” means the medically monitored use of certain substance use disorder medications in combination with treatment services.

78.28(3) Dental services. Dental services requiring prior approval are outlined in the Iowa Medicaid Dental Provider Manual as amended to July 1, 2026.

78.28(4) Optometric services and ophthalmic materials that must be submitted for prior approval are as follows:

a. A second lens correction within a 24-month period for members eight years of age and older. Payment will be made when the member’s vision has at least a five-tenths diopter of change in sphere or cylinder or ten-degree change in axis in either eye.

b. Visual therapy may be authorized when warranted by case history or diagnosis for a period of time not greater than 90 days. Should continued therapy be warranted, the prior approval process should be reaccomplished, accompanied by a report showing satisfactory progress. Approved diagnoses are convergence insufficiency and amblyopia. Visual therapy is not covered when provided by opticians.

c. Subnormal visual aids where near visual acuity is better than 20/100 at 16 inches, 2M print. Prior authorization is not required if near visual acuity as described above is less than 20/100. Subnormal aids include but are not limited to hand magnifiers, loupes, telescopic spectacles or reverse Galilean telescope systems.

d. Photochromatic tint. Approval will be given when the member has a documented medical condition that causes photosensitivity and less costly alternatives are inadequate.

e. Press-on prisms. Approval will be granted for members whose vision cannot be adequately corrected with other covered prisms.

For all of the above, the optometrist shall furnish sufficient information to clearly establish that these procedures are necessary in terms of the visual condition of the patient pursuant to rule 441—78.7(249A) and subrule 78.1(18).

78.28(5) Hearing aids that must be submitted for prior approval are:

a. Replacement of a hearing aid less than four years old (except when the member is under 21 years of age). The department will approve payment when the original hearing aid is lost or broken beyond repair or there is a significant change in the person’s hearing that would require a different hearing aid.

b. A hearing aid costing more than \$650. The department will approve payment for either of the following purposes:

(1) Educational purposes when the member is participating in primary or secondary education or in a postsecondary academic program leading to a degree and an in-office comparison of an analog aid and a digital aid matched (+/- 5dB) for gain and output shows a significant improvement in either speech recognition in quiet or speech recognition in noise or an in-office comparison of two aids, one of which is single channel, shows significantly improved audibility.

(2) Vocational purposes when documentation submitted indicates the necessity, such as varying amounts of background noise in the work environment and a need to converse in order to do the job and an in-office comparison of an analog aid and a digital aid matched (+/- 5dB) for gain and output shows a significant improvement in either speech recognition in quiet or speech recognition in noise or an in-office comparison of two aids, one of which is single channel, shows significantly improved audibility.

78.28(6) Hospital services requiring prior approval, preprocedure review or preadmission review are outlined in the Acute Hospitals Provider Manual as amended to July 1, 2026.

78.28(7) Ambulatory surgical centers are subject to prior approval and preprocedure review as set forth in the Ambulatory Surgical Centers Provider Manual as amended to July 1, 2026.

78.28(8) All assertive community treatment (ACT) services require prior approval. EXCEPTION: If ACT services are initiated before Medicaid eligibility is established, prior approval is required for ACT services beginning with the second month following notice of Medicaid eligibility.

a. Approval will be granted if ACT services are determined to be medically necessary. Approval will be limited to no more than 180 days.

b. A new prior approval must be obtained to continue ACT services after the expiration of a previous approval.

78.28(9) Nursing, psychosocial, developmental therapies and personal care services provided by a licensed child care center for members aged 20 or under require prior approval and will be approved if the services are determined to be medically necessary. The request for prior authorization shall include a nursing assessment, the plan of care, and supporting documentation and shall identify the types and service delivery levels of all other services provided to the member whether or not the services are reimbursable by Medicaid. Providers shall indicate the expected number of nursing, home health aide or behavior intervention hours per day, the number of days per week, and the number of weeks or months of service based on the plan of care using a combined hourly rate.

78.28(10) Private duty nursing or personal care services provided by a home health agency provider for persons aged 20 or under require prior approval and will be approved if determined to be medically necessary. Payment will be made on an hourly unit of service.

a. Definitions.

(1) Private duty nursing services are those services provided by a registered nurse or a licensed practical nurse under the direction of the member's physician to a member in the member's place of residence or outside the member's residence, when normal life activities take the member outside the place of residence. Place of residence does not include nursing facilities, ICFs/ID, or hospitals.

Services shall be provided according to a written plan of care authorized by a licensed physician. The home health agency is encouraged to collaborate with the member, or in the case of a child with the child's caregiver, in the development and implementation of the plan of treatment. These services shall exceed intermittent guidelines as defined in subrule 78.9(3). Private duty nursing and personal care services shall be inclusive of all home health agency services personally provided to the member.

Private duty nursing services do not include:

1. Respite care, which is a temporary intermission or period of rest for the caregiver.
2. Nurse supervision services including chart review, case discussion or scheduling by a registered nurse.
3. Services provided to other persons in the member's household.
4. Services requiring prior authorization that are provided without regard to the prior authorization process.

(2) Personal care services are those services provided by a home health aide or certified nurse's aide and that are delegated and supervised by a registered nurse under the direction of the member's physician to a member in the member's place of residence or outside the member's residence, when normal life activities take the member outside the place of residence. Place of residence does not include nursing facilities, ICFs/ID, or hospitals. Payment for personal care services for persons aged 20 and under that exceed intermittent guidelines may be approved if determined to be medically

necessary as defined in subrule 78.9(7). These services shall be in accordance with the member's plan of care and authorized by a physician. The home health agency is encouraged to collaborate with the member, or in the case of a child with the child's caregiver, in the development and implementation of the plan of treatment.

Medical necessity means the service is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent the worsening of conditions that endanger life, cause pain, result in illness or infirmity, threaten to cause or aggravate a disability or chronic illness, and no other equally effective course of treatment is available or suitable for the member requesting a service.

b. Requirements.

(1) Private duty nursing or personal care services shall be ordered in writing by a physician as evidenced by the physician's signature on the plan of care.

(2) Private duty nursing or personal care services will be authorized by the department or the department's designated review agent prior to payment.

(3) Prior authorization shall be requested at the time of initial submission of the plan of care or at any time the plan of care is substantially amended and will be renewed with the department or the department's designated review agent. Initial request for and request for renewal of prior authorization shall be submitted to the department's designated review agent. The provider of the service is responsible for requesting prior authorization and for obtaining renewal of prior authorization.

The request for prior authorization shall include a nursing assessment, the plan of care, and supporting documentation. The request for prior authorization shall include all items previously identified as required treatment plan information and shall further include: any planned surgical interventions and projected time frame; information regarding caregiver's desire to become involved in the member's care, to adhere to program objectives, to work toward treatment plan goals, and to work toward maximum independence; and identify the types and service delivery levels of all other services to the member whether or not the services are reimbursable by Medicaid. Providers shall indicate the expected number of private duty nursing RN hours, private duty nursing LPN hours, or home health aide hours per day, the number of days per week, and the number of weeks or months of service per discipline. If the member is currently hospitalized, the projected date of discharge shall be included.

Prior authorization approvals will not be granted for treatment plans that exceed 16 hours of home health agency services per day.

78.28(11) Replacement of vibrotactile aids less than four years old will be approved when the original aid is broken beyond repair or lost.

78.28(12) High-technology radiology procedures.

a. Except as provided in paragraph 78.28(12) "*b.*" the following radiology procedures require prior approval:

- (1) Magnetic resonance imaging (MRIs);
- (2) Computed tomography (CTs), including combined abdomen and pelvis CT scans;
- (3) Computed tomographic angiographs (CTAs);
- (4) Positron emission tomography (PETs); and
- (5) Magnetic resonance angiography (MRAs).

b. Notwithstanding paragraph 78.28(12) "*a.*," prior authorization is not required when any of the following applies:

(1) Radiology procedures are billed on a CMS 1500 claim for places of service "hospital inpatient" (POS 21) or "hospital emergency room" (POS 23), or on a UB04 claim with revenue code 45X;

(2) The member has Medicare coverage;

(3) A radiology procedure is ordered or requested by the department, a state district court, law enforcement, or other similar entity for the purposes of a child abuse/neglect investigation, as documented by the provider.

c. Prior approval will be granted if the procedure requested meets the requirements of 441—subrule 79.10(2), based on diagnosis, symptoms, history of illness, course of treatment, and treatment plan, as documented by the provider requesting prior approval.

d. Required requests for prior approval of radiology procedures must be submitted to the department.

e. When a member has received notice of retroactive Medicaid eligibility after receiving a radiology procedure for a date of service prior to the member's receipt of such notice and otherwise requiring prior approval pursuant to this rule, a retroactive authorization request must be submitted on an Outpatient Prior Authorization Request form and approved before any claim for payment is submitted.

[ARC 0315D, IAB 5/27/26, effective 7/1/26]

441—78.29(249A) Behavioral health services. Payment will be made for medically necessary behavioral health services provided by a participating marital and family therapist, independent social worker, master social worker, mental health counselor, or certified alcohol and drug counselor within the practitioner's scope of practice pursuant to state law and subject to the limitations and exclusions set forth in this rule.

78.29(1) Limitations.

a. An assessment and a treatment plan are required.

b. Services provided by a licensed master social worker must be provided under the supervision of an independent social worker qualified to participate in the Medicaid program.

78.29(2) Exclusions. Payment will not be approved for the following services:

a. Services provided in a medical institution.

b. Services performed without relationship to a specific condition, risk factor, symptom, or complaint.

c. Services provided for nonspecific conditions of distress such as job dissatisfaction or general unhappiness.

d. Sensitivity training, marriage enrichment, assertiveness training, and growth groups or marathons.

78.29(3) Payment.

a. Payment will be made only for time spent in face-to-face consultation with the member.

b. A unit of service is 15 minutes. Time spent with members shall be rounded to the quarter hour, where applicable.

[ARC 0315D, IAB 5/27/26, effective 7/1/26]

441—78.30(249A) Birth centers. Payment will be made for prenatal, delivery, and postnatal services as outlined in the Birth Centers Provider Manual as amended to July 1, 2026.

[ARC 0315D, IAB 5/27/26, effective 7/1/26]

441—78.31(249A) Hospital outpatient services.

78.31(1) Covered hospital outpatient services. Payment will be approved only for the following outpatient hospital services and medical services when provided on the licensed premises of the hospital. Hospitals with alternate sites approved by the department of inspections, appeals, and licensing are acceptable sites. All outpatient services listed in paragraphs 78.31(1)“g” through “m” are subject to a random sample retrospective review for medical necessity by Iowa Medicaid. All services may also be subject to a more intensive retrospective review if abuse is suspected. Services in paragraphs 78.31(1)“a” through “f” shall be provided in hospitals on an outpatient basis and are subject to no further limitations except medical necessity of the service.

Services listed in paragraphs 78.31(1)“g” through “m” shall be provided by hospitals on an outpatient basis and must be certified by the department before payment may be made. Other limitations apply to these services.

a. Emergency service.

- b. Outpatient surgery.
- c. Laboratory, X-ray and other diagnostic services.
- d. General or family medicine.
- e. Follow-up or after-care specialty clinics.
- f. Physical medicine and rehabilitation.
- g. Substance use disorder.
- h. Eating disorders.
- i. Cardiac rehabilitation.
- j. Mental health.
- k. Pain management.
- l. Diabetic education.
- m. Pulmonary rehabilitation.
- n. Nutritional counseling for persons aged 20 and under.

78.31(2) *Requirements for all outpatient services.*

a. *Need for service.* It must be clearly established that the service meets a documented need in the area served by the hospital. There must be documentation of studies completed, consultations with other health care facilities and health care professionals in the area, community leaders, and organizations to determine the need for the service and to tailor the service to meet that particular need.

b. *Professional direction.* All outpatient services must be provided by or at the direction and under the supervision of a medical doctor or osteopathic physician except for mental health services which may be provided by or at the direction and under the supervision of a medical doctor, osteopathic physician, or certified health service provider in psychology.

c. *Goals and objectives.* The goals and objectives of the program must be clearly stated. Paragraphs 78.31(2)“d” and “f” and the organization and administration of the program must clearly contribute to the fulfillment of the stated goals and objectives.

d. *Treatment modalities used.* The service must employ multiple treatment modalities and professional disciplines. The modalities and disciplines employed must be clearly related to the condition or disease being treated.

e. *Criteria for selection and continuing treatment of patients.* The condition or disease proposed to be treated must be clearly stated. Any indications for treatment or contraindications for treatment must be set forth together with criteria for determining the continued medical necessity of treatment.

f. *Length of program.* There must be established parameters that limit the program either in terms of its overall length or in terms of number of visits, etc.

g. *Monitoring of services.* The services provided by the program must be monitored and evaluated to determine the degree to which patients are receiving accurate assessments and effective treatment.

The monitoring of the services must be an ongoing plan and systematic process to identify problems in patient care or opportunities to improve patient care.

The monitoring and evaluation of the services are based on the use of clinical indicators that reflect those components of patient care important to quality.

h. *Vaccines.* In order to be paid for the outpatient administration of a vaccine covered under the VFC program, a hospital must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

78.31(3) *Application for certification.* Hospital outpatient programs listed in paragraphs 78.31(1)“g” through “m” must submit an application to Iowa Medicaid for certification before payment will be made. Iowa Medicaid will review the application against the requirements for the specific type of outpatient service and notify the provider whether certification has been approved.

Applications will consist of a narrative providing the following information:

a. Documented need for the program including studies, needs assessments, and consultations with other health care professionals.

- b. Goals and objectives of the program.
- c. Organization and staffing including how the program fits with the rest of the hospital, the number of staff, staff credentials, and the staff's relationship to the program, e.g., hospital employee, contractual consultant.
- d. Policies and procedures including admission criteria, patient assessment, treatment plan, discharge plan and postdischarge services, and the scope of services provided, including treatment modalities.
- e. Any accreditations or other types of approvals from national or state organizations.
- f. The physical facility and any equipment to be utilized, and whether the facility is part of the hospital license.

78.31(4) *Requirements for specific types of service.*

- a. Substance use disorder.
 - (1) Approval by joint commission. In addition to certification by the department, substance use disorder programs must also be approved by the joint commission.
 - (2) General characteristics. The services must be designed to identify and respond to the biological, psychological and social antecedents, influences and consequences associated with the recipient's dependence.

These needed services must be provided either directly by the facility or through referral, consultation or contractual arrangements or agreements.

Special treatment needs of recipients by reason of age, sex, sexual orientation, or ethnic origin are evaluated and services for children and adolescents (as well as adults, if applicable) address the special needs of these age groups including but not limited to learning problems in education, family involvement, developmental status, nutrition, and recreational and leisure activities.

- (3) Diagnostic and treatment staff. Each person who provides diagnostic or treatment services shall be determined to be competent to provide the services by reason of education, training, and experience.

Professional disciplines that must be represented on the diagnostic and treatment staff, either through employment by the facility (full-time or part-time), contract or referral, are a physician (M.D. or D.O.), a licensed psychologist and a substance use counselor certified by the Iowa board of certification. Psychiatric consultation must be available and the number of staff should be appropriate to the patient load of the facility.

- (4) Initial assessment. A comprehensive assessment of the biological, psychological, social, and spiritual orientation of the patient must be conducted that shall include:

- 1. A history of the use of alcohol and other drugs including age of onset, duration, patterns, and consequences of use; use of alcohol and drugs by family members and types of and responses to previous treatment.

- 2. A comprehensive medical history and physical examination including the history of physical problems associated with dependence.

- 3. Appropriate laboratory screening tests based on findings of the history and physical examination and tests for communicable diseases when indicated.

- 4. Any history of physical abuse.

- 5. A systematic mental status examination with special emphasis on immediate recall and recent and remote memory.

- 6. A determination of current and past psychiatric and psychological abnormality.

- 7. A determination of any degree of danger to self or others.

- 8. The family's history of substance use disorders.

- 9. The patient's educational level, vocational status, and job performance history.

- 10. The patient's social support networks, including family and peer relationships.

- 11. The patient's perception of the patient's strengths, problem areas, and dependencies.

- 12. The patient's leisure, recreational, or vocational interests and hobbies.

- 13. The patient's ability to participate with peers and in programs and social activities.

14. Interviews of family members and significant others as available with the patient's written or verbal permission.

15. The patient's legal problems, if applicable.

(5) Admission criteria. Both of the first two criteria and one additional criterion from the following list must be present for a patient to be accepted for treatment.

1. Alcohol or drugs taken in greater amounts over a longer period than the person intended.

2. Two or more unsuccessful efforts to cut down or control use of alcohol or drugs.

3. Continued alcohol or drug use despite knowledge of having a persistent or recurrent family, social, occupational, psychological, or physical problem that is caused or exacerbated by the use of alcohol or drugs.

4. Marked tolerance: the need for markedly increased amounts of alcohol or drugs (i.e., at least a 50 percent increase) in order to achieve intoxication or desired effect or markedly diminished effect with continued use of same amount.

5. Characteristic withdrawal symptoms.

6. Alcohol or drugs taken often to relieve or avoid withdrawal symptoms.

(6) Plan of treatment. For each patient, there is a written comprehensive and individualized description of treatment to be undertaken. The treatment plan is based on the problems and needs identified in the assessment and specifies the regular times at which the plan will be reassessed to determine current clinical problems, needs, and responses to treatment. The plan shall include documentation of:

1. The patient's perception of needs and, when appropriate and available, the family's perception of the patient's needs.

2. The patient's participation in the development of the treatment plan.

3. Changes in treatment.

(7) Discharge plan. For each patient before discharge, a plan for discharge is designed to provide appropriate continuity of care that meets the following requirements:

1. The plan for continuing care must describe and facilitate the transfer of the patient and the responsibility for the patient's continuing care to another phase or modality of the program, other programs, agencies, persons or to the patient and the patient's personal support system.

2. The plan is in accordance with the patient's reassessed needs at the time of transfer.

3. The plan is developed in collaboration with the patient and, as appropriate and available, with the patient's written verbal permission with family members.

4. The plan is implemented in a manner acceptable to the patient and the need for confidentiality.

5. Implementation of the plan includes timely and direct communication with and transfer of information to the other programs, agencies, or persons who will be providing continuing care.

(8) Restrictions and limitations on payment. Medicaid will reimburse for a maximum of 28 treatment days. Payment beyond 28 days is made when documentation indicates that the patient has not reached an exit level. If an individual has completed all or part of the basic 28-day program, a repeat of the program will be reimbursed with justification. The program will include an aftercare component meeting weekly for at least one year without charge.

b. Eating disorders.

(1) General characteristics. Eating disorders are characterized by gross disturbances in eating behavior. Eating disorders include anorexia nervosa or bulimia nervosa. Compulsive overeaters are not approved for this program.

(2) Diagnostic and treatment staff. Each person who provides diagnostic or treatment services shall be determined to be competent to provide the services by reason of education, training, and experience.

Professional disciplines that must be represented on the diagnostic and treatment staff, either through employment by a facility (full-time or part-time), contract or referral, are a physician (M.D. or D.O.), a licensed psychologist, a counselor with a master's or bachelor's degree and experience,

a dietitian with a bachelor's degree and registered dietitian's certificate, and a licensed occupational therapist. The number of staff should be appropriate to the patient load of the facility.

(3) Initial assessment. A comprehensive assessment of the biological, psychological, social, and family orientation of the patient must be conducted. The assessment must include a weight history and a history of the patient's eating and dieting behavior, including binge eating, onset, patterns, and consequences. The assessment shall include the following:

1. A family history as well as self-assessment regarding chronic dieting, obesity, anorexia, bulimia, drug abuse, alcohol problems, depression, hospitalization for psychiatric reasons, and threatened or attempted suicide.

2. A history of purging behavior including frequency and history of vomiting, use of laxatives, history and frequency of use of diuretics, history and frequency of use of diet pills, ipecac, or any other weight control measures, and frequency of eating normal meals without vomiting.

3. A history of exercise behavior, including type, frequency, and duration.

4. A complete history of current alcohol and other drug use.

5. Any suicidal thoughts or attempts.

6. Sexual history, including sexual preference and activity. Sexual interest currently as compared to prior to the eating disorder is needed.

7. History of experiencing physical or sexual (incest or rape) abuse.

8. History of other counseling experiences.

9. Appropriate psychological assessment, including psychological orientation to the above questions.

10. A medical history, including a physical examination, covering the information listed in subparagraph 78.31(4) "b"(4).

11. Appropriate laboratory screening tests based on findings of the history and physical examination and tests for communicable diseases when indicated.

12. The patient's social support networks, including family and peer relationships.

13. The patient's educational level, vocational status, and job or school performance history, as appropriate.

14. The patient's leisure, recreational, or vocational interests and hobbies.

15. The patient's ability to participate with peers and programs and social activities.

16. Interview of family members and significant others as available with the patient's written or verbal permission as appropriate.

17. Legal problems, if applicable.

(4) Admission criteria. In order to be accepted for treatment, the patient shall meet the diagnostic criteria for anorexia nervosa or bulimia nervosa as established by the DSM (Diagnostic and Statistical Manual of Mental Disorders as amended to July 1, 2026) published by the American Psychiatric Association. In addition to the diagnostic criteria, the need for treatment will be determined by a demonstrable loss of control of eating behaviors and the failure of the patient in recent attempts at voluntary self-control of the problem. Demonstrable impairment, dysfunction, disruption or harm of physical health, emotional health (e.g., significant depression withdrawal, isolation, suicidal ideas), vocational or educational functioning, or interpersonal functioning (e.g., loss of relationships, legal difficulties) shall have occurred. The need for treatment may be further substantiated by substance use, out-of-control spending, incidence of stealing to support habit, or compulsive gambling. The symptoms shall have been present for at least six months and three of the following criteria must be present:

1. Medical criteria including endocrine and metabolic factors (e.g., amenorrhea, menstrual irregularities, decreased reflexes, cold intolerance, hypercarotenemia, parotid gland enlargement, lower respiration rate, hair loss, abnormal cholesterol or triglyceride levels).

2. Other cardiovascular factors including hypotension, hypertension, arrhythmia, ipecac poisoning, fainting, or bradycardia.

3. Renal considerations including diuretic abuse, dehydration, elevated BUN, renal calculi, edema, or hypokalemia.
4. Gastrointestinal factors including sore throats, Mallory-Weiss tears, decreased gastric emptying, constipation, abnormal liver enzymes, rectal bleeding, laxative abuse, or esophagitis.
5. Hematologic considerations including anemia, leukopenia, or thrombocytopenia.
6. Ear, nose, and throat factors including headaches or dizziness.
7. Skin considerations including lanugo or dry skin.
8. Aspiration pneumonia, a pulmonary factor.

The presence of severe symptoms and complications as evaluated and documented by the medical director may require a period of hospitalization to establish physical or emotional stability.

(5) Plan of treatment. For each patient, there is a written comprehensive and individualized description of treatment to be undertaken. The treatment plan is based on problems and needs identified in the assessment and specifies the regular times at which the plan will be reassessed to determine current clinical problems, needs, and responses to treatment. The plan shall document:

1. The patient's perceptions of needs and, when appropriate and available, the family's perceptions of the patient's needs.
2. The patient's participation in the development of the treatment plans.
3. Changes in treatment.

(6) Discharge plan. Plans for discharge shall meet the requirements for discharge plans for alcohol and substance use patients in subparagraph 78.31(4) "a"(7).

(7) Restriction and limitations on payment. Medicaid will pay for a maximum of 30 days of a structured outpatient treatment program. Payment beyond 30 days is made when documentation indicates that the patient has not reached an exit level.

Eating disorder programs will include an aftercare component meeting weekly for at least one year without charge.

Family counseling groups held in conjunction with the eating disorders program will be part of the overall treatment charge.

c. Cardiac rehabilitation.

(1) General characteristics. Cardiac rehabilitation programs shall provide a supportive educational environment in which to facilitate behavior change with respect to the accepted cardiac risk factors, initiate prescribed exercise as a mode of facilitating the return of the patient to everyday activities by improving cardiovascular functional capacity and work performance, and promote a long-term commitment to lifestyle changes that could positively affect the course of the cardiovascular disease process.

(2) Treatment staff. Professional disciplines who must be represented on the treatment staff, either by employment by the facility (full-time or part-time), contract or referral, are as follows:

1. At least one physician, ARNP, or PA responsible for responding to emergencies must be physically present in the hospital when patients are receiving cardiac rehabilitation services. The physician, ARNP, or PA must be trained and certified at least to the level of basic life support.
2. A medical consultant shall oversee the policies and procedures of the outpatient cardiac rehabilitation area. The director shall meet with the cardiac rehabilitation staff on a regular basis to review exercise prescriptions and any concerns of the team.
3. A cardiac rehabilitation nurse shall carry out the exercise prescription after assessment of the patient. The nurse shall be able to interpret cardiac dysrhythmia and be able to initiate emergency action if necessary. The nurse shall assess and implement a plan of care for cardiac risk factor modification. The nurse shall have at least one year of experience in a coronary care unit.
4. A physical therapist shall offer expertise in unusual exercise prescriptions where a patient has an unusual exercise problem.
5. A dietitian shall assess the dietary needs of persons and appropriately instruct them on their prescribed diets.

6. A social worker shall provide counseling as appropriate and facilitate a spouse support group. A licensed occupational therapist shall be available as necessary.

(3) Admission criteria. Candidates for the program must be referred by the attending physician. The following conditions are eligible for the program:

1. Postmyocardial infarction (within three months postdischarge).
2. Postcardiac surgery (within three months postdischarge).
3. Poststreptokinase.
4. Postpercutaneous transluminal angioplasty (within three months postdischarge).
5. Patient with severe angina being treated medically because of client or doctor preference or inoperable cardiac disease.

(4) Physical environment and equipment. A cardiac rehabilitation unit must be an autonomous physical unit specifically equipped with the necessary telemetry monitoring equipment, exercise equipment, and appropriate equipment and supplies for cardiopulmonary resuscitation (CPR). The exercise equipment must have the capacity to measure the intensity, speed, and length of the exercises. The equipment must be periodically inspected and maintained in accordance with the hospital's preventive maintenance program.

(5) Medical records. Medical records for each cardiac rehabilitation patient shall consist of at least the following:

1. Referral form.
2. Physician's orders.
3. Laboratory reports.
4. Electrocardiogram reports.
5. History and physical examination.
6. Angiogram report, if applicable.
7. Operative report, if applicable.
8. Preadmission interview.
9. Exercise prescription.
10. Rehabilitation plan, including participant's goals.
11. Documentation for exercise sessions and progress notes.
12. Nurse's progress reports.
13. Discharge instructions.

(6) Discharge plan. The patient will be discharged from the program when the physician, staff, and patient agree that the work level is functional for them and little benefit could be derived from further continuation of the program, dysrhythmia disturbances are resolved, and appropriate cardiovascular response to exercise is accomplished.

(7) Monitoring of services. The program should be monitored by the hospital on a periodic basis using measuring criteria for evaluating cardiac rehabilitation services provided.

(8) Restrictions and limitations. Payment will be made for a maximum of three visits per week for a period of 12 weeks. Payment beyond 12 weeks is made when documentation indicates that the patient has not reached an exit level.

d. Mental health.

(1) General characteristics. To be covered, mental health services must be prescribed by a physician or certified health service provider in psychology, provided under an individualized treatment plan and reasonable and necessary for the diagnosis or treatment of the patient's condition. This means the services must be for the purpose of diagnostic study or the services must reasonably be expected to improve the patient's condition.

(2) Individualized treatment plan. The individualized written plan of treatment shall be established by a physician or certified health service provider in psychology after any needed consultation with appropriate staff members. The plan must state the type, amount, frequency and duration of the services to be furnished and indicate the diagnoses and anticipated goals. (A plan is not required if only a few brief services will be furnished.)

(3) Supervision and evaluation. Services must be supervised and periodically evaluated by a physician, certified health service provider in psychology, or both within the scopes of their respective practices if clinically indicated to determine the extent to which treatment goals are being realized. The evaluation must be based on periodic consultation and conference with therapists and staff. The physician or certified health service provider in psychology must also provide supervision and direction to any therapist involved in the patient's treatment and see the patient periodically to evaluate the course of treatment and to determine the extent to which treatment goals are being realized and whether changes in direction or services are required.

(4) Reasonable expectation of improvement. Services must be for the purpose of diagnostic study or reasonably be expected to improve the patient's condition. The treatment must at a minimum be designed to reduce or control the patient's psychiatric or psychological symptoms so as to prevent relapse or hospitalization and improve or maintain the patient's level of functioning.

It is not necessary that a course of therapy have as its goal restoration of the patient to the level of functioning exhibited prior to the onset of the illness although this may be appropriate for some patients. For many other patients, particularly those with long-term chronic conditions, control of symptoms and maintenance of a functional level to avoid further deterioration or hospitalization is an acceptable expectation of improvement. "Improvement" in this context is measured by comparing the effect of continuing versus discontinuing treatment. Where there is a reasonable expectation that if treatment services were withdrawn, the patient's condition would deteriorate, relapse further, or require hospitalization, this criterion would be met.

(5) Diagnostic and treatment staff. Each person who provides diagnostic or treatment services shall be determined to be competent to provide the services by reason of education, training, and experience. The number of the above staff employed by the facility must be appropriate to the facility's patient load. The staff may be employees of the hospital, on contract, or the service may be provided through referral. The diagnostic and treatment staff shall consist of a physician, a psychologist, social workers or counselors meeting the requirements for "mental health professionals" as set forth in rule 441—24.1(225A).

(6) Initial assessment. A comprehensive assessment of the biological, psychological, social, and spiritual orientation of the patient must be conducted, including:

1. A history of the mental health problem, including age of onset, duration, patterns of symptoms, consequences of symptoms, and responses to previous treatment.
2. A comprehensive clinical history, including the history of physical problems associated with the mental health problem. Appropriate referral for physical examination for determination of any communicable diseases.
3. Any history of physical abuse.
4. A systematic mental health examination, with special emphasis on any change in cognitive, social or emotional functioning.
5. A determination of current and past psychiatric and psychological abnormality.
6. A determination of any degree of danger to self or others.
7. The family's history of mental health problems.
8. The patient's educational level, vocational status, and job performance history.
9. The patient's social support network, including family and peer relationship.
10. The patient's perception of the patient's strengths, problem areas, and dependencies.
11. The patient's leisure, recreational or vocational interests and hobbies.
12. The patient's ability to participate with peers in programs and social activities.
13. Interview of family members and significant others, as available, with the patient's written or verbal permission.
14. Legal problems if applicable.

(7) Covered services. Services covered for the treatment of psychiatric conditions are:

1. Individual and group therapy with physicians, psychologists, social workers, counselors, or psychiatric nurses.

2. Occupational therapy services if the services require the skills of a qualified occupational therapist and must be performed by or under the supervision of a licensed occupational therapist or by an occupational therapy assistant.

3. Drugs and biologicals furnished to outpatients for therapeutic purposes only if they are of the type that cannot be self-administered and are not “covered Part D drugs” as defined by 42 U.S.C. Section 1395w-102(e)(1)-(2) as amended to July 1, 2026, for a “Part D eligible individual” as defined in 42 U.S.C. Section 1395w-101(a)(3)(A) as amended to July 1, 2026, including an individual who is not enrolled in a Part D plan.

4. Activity therapies that are individualized and essential for the treatment of the patient’s condition. The treatment plan must clearly justify the need for each particular therapy utilized and explain how it fits into the patient’s treatment.

5. Family counseling services are covered only if the primary purpose of the counseling is the treatment of the patient’s condition.

6. Partial hospitalization and day treatment services to reduce or control a person’s psychiatric or psychological symptoms so as to prevent relapse or hospitalization, improve or maintain the person’s level of functioning and minimize regression. These services include all psychiatric services needed by the patient during the day.

- Partial hospitalization services means an active treatment program that provides intensive and structured support that assists persons during periods of acute psychiatric or psychological distress or during transition periods, generally following acute inpatient hospitalization episodes.

- Service components may include individual and group therapy, reality orientation, stress management and medication management.

- Services are provided for a period for four to eight hours per day.

- Day treatment services means structured, long-term services designed to assist in restoring, maintaining or increasing levels of functioning, minimizing regression and preventing hospitalization.

- Service components include training in independent functioning skills necessary for self-care, emotional stability and psychosocial interactions, and training in medication management.

- Services are structured with an emphasis on program variation according to individual need.

- Services are provided for a period of three to five hours per day, three or four times per week.

7. Partial hospitalization and day treatment for persons aged 20 or under. Payment to a hospital will be approved for day treatment services for persons aged 20 or under if the hospital is certified by the department for hospital outpatient mental health services. All conditions for the day treatment program for persons aged 20 or under as outlined in subrule 78.16(7) for community mental health centers shall apply to hospitals. All conditions of the day treatment program for persons aged 20 or under as outlined in subrule 78.16(7) for community mental health centers shall be applicable for the partial hospitalization program for persons aged 20 or under with the exception that the maximum hours shall be 25 hours per week.

(8) Restrictions and limitations on coverage. The following are generally not covered, except as indicated:

1. Activity therapies, group activities, or other services and programs that are primarily recreational or diversional in nature. Outpatient psychiatric day treatment programs that consist entirely of activity therapies are not covered.

2. Geriatric day-care programs, which provide social and recreational activities to older persons who need some supervision during the day while other family members are away from home. These programs are not covered because they are not considered reasonable and necessary for a diagnosed psychiatric disorder.

3. Vocational training. While occupational therapy may include vocational and prevocational assessment of training, when the services are related solely to specific employment opportunities, work skills, or work setting, they are not covered.

(9) Frequency and duration of services. There are no specific limits on the length of time that services may be covered. There are many factors that affect the outcome of treatment. Among them

are the nature of the illness, prior history, the goals of treatment, and the patient's response. As long as the evidence shows that the patient continues to show improvement in accordance with the individualized treatment plan and the frequency of services is within acceptable norms of medical practice, coverage will be continued.

(10) Documentation requirements. The provider shall develop and maintain sufficient written documentation to support each medical or remedial therapy, service, activity, or session for which billing is made. All outpatient mental health services shall include:

1. The specific services rendered.
2. The date and actual time the services were rendered.
3. Who rendered the services.
4. The setting in which the services were rendered.
5. The amount of time it took to deliver the services.
6. The relationship of the services to the treatment regimen described in the plan of care.
7. Updates describing the patient's progress.

For services that are not specifically included in the patient's treatment plan, a detailed explanation of how the services being billed relate to the treatment regimen and objectives contained in the patient's plan of care and the reason for the departure from the plan shall be given.

e. Pain management.

(1) Approval by commission on accreditation of rehabilitation facilities. In addition to certification by the department, pain management programs must also be approved by the commission on accreditation of rehabilitation facilities (CARF).

(2) General characteristics. A chronic pain management program shall provide coordinated, goal-oriented, interdisciplinary team services to reduce pain, improve quality of life, and decrease dependence on the health care system for persons with pain which interferes with physical, psychosocial, and vocational functioning.

(3) Treatment staff. Each person who provides treatment services shall be determined to be competent to provide the services by reason of education, training, and experience. Professional disciplines which must be represented on the treatment staff, either through employment by the facility (full-time or part-time), contract or referral, are a physician (M.D. or D.O.), a registered nurse, a licensed physical therapist and a licensed clinical psychologist or psychiatrist. The number of staff should be appropriate to the patient load of the facility.

(4) Admission criteria. Candidates for the program shall meet the following guidelines:

1. The person must have had adequate medical evaluation and treatment in the months preceding admission to the program including an orthopedic or neurological consultation if the problem is back pain or a neurological evaluation if the underlying problem is headaches.
2. The person must be free of any underlying psychosis or severe neurosis.
3. The person cannot be toxic on any addictive drugs.
4. The person must be capable of self-care, including being able to get to meals and to perform activities of daily living.

(5) Plan of treatment. For each patient there is a written comprehensive and individualized description of treatment to be undertaken. The treatment plan is based on the problems and needs identified in the assessment and specifies the times at which the plan will be reassessed to determine current clinical problems, needs, and responses to treatment. The plan shall document:

1. The patient's perception of needs and, when appropriate and available, the family's perception of the patient's needs.
2. The patient's participation in the development of the treatment plan.
3. Changes in treatment are documented.

(6) Discharge plan. For each patient before discharge, a plan for discharge is designed to provide appropriate continuity of care that meets the following requirements:

1. The plan for continuing care must describe and facilitate the transfer of the patient and the responsibility for the patient's continuing care to another phase or modality of the program, other programs, agencies, persons or to the patient and the patient's personal support system.

2. The plan is in accordance with the patient's reassessed needs at the time of transfer.

3. The plan is developed in collaboration with the patient and, as appropriate and available, with the patient's written verbal permission with the family members.

4. The plan is implemented in a manner acceptable to the patient and the need for confidentiality.

Implementation of the plan includes timely and direct communication with and transfer of information to the other programs, agencies, or persons who will be providing continuing care.

(7) Restrictions and limitations on payment. Medicaid will pay for a maximum of three weeks of a structured outpatient treatment program. When documentation indicates that the patient has not reached an exit level, coverage may be extended an extra week.

A repeat of the entire program for any patient will be covered only if a different disease process is causing the pain or a significant change in life situation can be demonstrated.

f. Diabetic education.

(1) General characteristics. An outpatient diabetes self-management education program shall provide instruction that will enable people with diabetes and their families to understand the diabetes disease process and the daily management of diabetes. People with diabetes must learn to balance their special diet and exercise requirements with drug therapy (insulin or oral agents). They must learn self-care techniques such as monitoring their own blood glucose. And often, they must learn to self-treat insulin reactions, protect feet that are numb and have seriously compromised circulation, and accommodate their regimen to changes in blood glucose because of stress or infections.

(2) Program staff. Each person who provides services shall be determined to be competent to provide the services by reason of education, training and experience. Professional disciplines which must be represented on the staff, either through employment by the facility (full-time or part-time), contract or referral, are a physician (M.D. or D.O.), a registered nurse, a registered dietitian and a licensed pharmacist. The number of staff should be appropriate to the patient load of the facility.

(3) Admission criteria. Candidates for the program shall meet the following guidelines:

1. The person must have Type I or Type II diabetes.

2. The person must be referred by the attending physician.

3. The person shall demonstrate an ability to follow through with self-management.

(4) Health assessment. An individualized and documented assessment of needs shall be developed with the patient's participation. Follow-up assessments, planning and identification of problems shall be provided.

(5) Restrictions and limitations on payment. Medicaid will pay for a diabetic self-management education program. Diabetic education programs will include follow-up assessments at 3 and 12 months without charge.

g. Pulmonary rehabilitation.

(1) General characteristics. Pulmonary rehabilitation is an individually tailored, multidisciplinary program through which accurate diagnosis, therapy, emotional support, and education stabilizes or reverses both the physio- and psychopathology of pulmonary diseases and attempts to return the patient to the highest possible functional capacity allowed by the pulmonary handicap and overall life situation.

(2) Diagnostic and treatment staff. Each person who provides diagnostic or treatment services shall be determined to be competent to provide the services by reason of education, training, and experience.

Professional disciplines that must be represented by the diagnostic and treatment staff, either through employment by the facility (full-time or part-time), contract, or referral, are a physician (doctor of medicine or osteopathy), a respiratory therapist, a licensed physical therapist, and a registered nurse.

(3) Initial assessment. A comprehensive assessment must occur initially, including:

1. A diagnostic workup that entails proper identification of the patient's specific respiratory ailment, appropriate pulmonary function studies, a chest radiograph, an electrocardiogram and, when indicated, arterial blood gas measurements at rest and during exercise, sputum analysis and blood theophylline measurements.

2. Behavioral considerations, including an emotional screening assessment and treatment or counseling when required, estimating the patient's learning skills and adjusting the program to the patient's ability, assessing family and social support, potential employment skills, employment opportunities, and community resources.

(4) Admission criteria. Criteria include a patient's being diagnosed and symptomatic of chronic obstructive pulmonary disease (COPD); having cardiac stability and social, family, and financial resources; having the ability to tolerate periods of sitting time; and being a nonsmoker for six months or, if a smoker, willingness to quit and having a physician's order to participate anyway. Factors that would make a person ineligible include acute or chronic illness that may interfere with rehabilitation, any illness or disease state that affects comprehension or retention of information, a strong history of medical noncompliance, unstable cardiac or cardiovascular problems, and orthopedic difficulties that would prohibit exercise.

(5) Plan of treatment. Individualized long- and short-term goals will be developed for each patient. The treatment goals will be based on the problems and needs identified in the assessment and specify the regular times at which the plan will be reassessed to determine current clinical problems, needs, and responses to treatment. The patients and their families need to help determine and fully understand the goals, so that they realistically approach the treatment phase. Changes in treatment must be documented. Components of pulmonary rehabilitation to be included are:

1. Physical therapy and relaxation techniques,
2. Exercise conditioning or physical conditioning for those with exercise limitations,
3. Respiratory therapy, education, an emphasis on the importance of smoking cessation, and
4. Nutritional information.

(6) Discharge plan. Ongoing care will generally be the responsibility of the primary care physician. Periodic reassessment will be conducted to evaluate progress and allow for educational reinforcement.

(7) Restrictions and limitations on payment. Medicaid will pay for a maximum of 25 treatment days. Payment beyond 25 days is made when documentation indicates that the patient has not reached an exit level.

h. Nutritional counseling. Payment will be made for persons aged 20 and under for nutritional counseling provided by a licensed dietitian employed by or under contract with a hospital for a nutritional problem or condition of a degree of severity that nutritional counseling beyond that normally expected as part of the standard medical management is warranted. For persons eligible for the WIC program, a WIC referral is required. Medical necessity for nutritional counseling services exceeding those available through WIC shall be documented.

[ARC 0315D, IAB 5/27/26, effective 7/1/26]

441—78.32(249A) Area education agencies. Payment will be made for physical therapy, occupational therapy, psychological evaluations and counseling, psychotherapy, speech-language therapy, and audiological, nursing, and vision services provided by an area education agency (AEA). Services shall be provided directly by the AEA or through contractual arrangement with the AEA.

[ARC 0315D, IAB 5/27/26, effective 7/1/26]

441—78.33(249A) Case management services. Payment will be approved for targeted case management services that are provided pursuant to 441—Chapter 90 to:

1. Members who are 18 years of age or over and have a primary diagnosis of intellectual disability, developmental disabilities, or chronic mental illness as defined in rule 441—90.1(249A).

2. Members who are under 18 years of age and are eligible to receive services under the HCBS intellectual disability waiver or children's mental health waiver.

[ARC 0315D, IAB 5/27/26, effective 7/1/26]

441—78.34(249A) HCBS health and disability waiver services. Payment will be approved for the following services to members eligible for HCBS health and disability waiver services as established in 441—Chapter 83 and as identified in the member's service plan. Payment will only be made for services provided in integrated, community-based settings that support full access of members receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS. For the purposes of this rule, "HCBS Provider Manual" means the department's manual that outlines provider-specific policies applicable to providers of HCBS services. The manual is available on the department's website. All references to the HCBS Provider Manual herein are as amended to July 1, 2026.

78.34(1) Home maintenance support services. Home maintenance support services encompass assistance required to maintain the participant's home as a clean, sanitary, and safe environment, provided when neither the participant nor any household person is capable of performing these tasks and no other relative, caregiver, or landlord is responsible for them. These services are particularly essential when the participant lives alone or when the usual caregiver needs support in performing these functions. "Usual caregiver" means an unpaid person who resides with the member and is available on a 24-hour per-day basis to assume responsibility for the care of the member.

a. These may involve tasks such as:

(1) Essential shopping, such as shopping for basic need items such as food, clothing or personal care items, or drugs.

(2) Limited housecleaning, such as maintenance cleaning such as vacuuming, dusting, scrubbing floors, defrosting refrigerators, cleaning stoves, cleaning medical equipment, washing and mending clothes, washing personal items used by the client, and washing dishes.

(3) Window and door maintenance, such as hanging screen windows and doors, replacing window panes, and washing windows.

(4) Minor repairs to walls, floors, stairs, railings, and handles.

(5) Heavy cleaning, such as cleaning attics or basements to remove fire hazards, moving heavy furniture, extensive wall washing, floor care or painting and trash removal.

(6) Mowing lawns and removing snow and ice from sidewalks and driveways.

(7) Tree or bush trimming when the tree or bush impairs safe navigation of the exterior of the home.

(8) Pest eradication and one-time cleaning following the pest eradication necessary for the person's health and safety.

b. Excluded services and costs. Services, activities, costs, and time that are not covered include but are not limited to:

(1) Tree trimming.

(2) Trash burning.

(3) Tree removal.

78.34(2) Home health aide services. Home health aide services are an extension of the state plan and are personal or direct care services provided to the member in the member's home that are not otherwise payable under Medicaid as set forth in rule 441—78.9(249A). A unit of service is a visit. A visit is defined as 15 minutes to 120 minutes.

a. Components of the service include but are not limited to:

(1) Observation and reporting of physical or emotional needs.

(2) Helping a member with bath, shampoo, or oral hygiene.

(3) Helping a member with toileting.

- (4) Helping a member in and out of bed and with ambulation.
- (5) Helping a member reestablish activities of daily living.
- (6) Assisting with oral medications ordered by the physician that are ordinarily self-administered.
- (7) Performing incidental household services that are essential to the member's health care at home and are necessary to prevent or postpone institutionalization in order to complete a full unit of service.

b. In some cases, a nurse may provide home health services if the health of the client is such that the agency is unable to place an aide in that situation due to limitations by state law or in the event that the agency's Medicare certification requirements prohibit the aide from providing the service. It is not permitted for the convenience of the provider.

c. Skilled nursing care is not covered.

78.34(3) *Adult day care services.*

a. Supports provided during day care are protective oversight, supervision, and support with activities of daily living (ADLs) and instrumental activities of daily living (IADLs). Included are personal care (i.e., ambulation, toileting, feeding, assisting with medications), behavioral support, or intermittent health-related cares not otherwise paid under other waiver or state plan programs.

b. A unit of service is 15 minutes (up to four units per day), a half day (1.25 to 4 hours per day), a full day (4.25 to 8 hours per day), or an extended day (8.25 to 12 hours per day).

78.34(4) *Nursing care services.* Nursing care services are services that are included in the plan of treatment approved by the physician and that are provided by licensed nurses to members in the home and community. The services shall be reasonable and necessary to the treatment of an illness or injury and include all nursing tasks recognized by the Iowa board of nursing. A unit of service is a visit.

78.34(5) *Respite care services.* Respite care services are services provided to the member that give temporary relief to the usual caregiver and provide all the necessary care that the usual caregiver would provide during that period. The purpose of respite care is to enable the member to remain in the member's current living situation.

a. Services provided outside the member's home shall not be reimbursable if the living unit where respite is provided is reserved for another person on a temporary leave of absence.

b. Member-to-staff ratios shall be appropriate to the individual needs of the member as determined by the member's interdisciplinary team.

c. A unit of service is 15 minutes.

d. Respite care is not to be provided to members during the hours in which the usual caregiver is employed except when the member is attending a 24-hour residential camp. Respite care shall not be used as a substitute for a child's day care. Respite cannot be provided to a member whose usual caregiver is an attendant care or supported community living provider for the member.

e. The interdisciplinary team shall determine if the member will receive basic individual respite, specialized respite, or group respite as defined in 441—Chapter 83.

f. A maximum of 14 consecutive days of 24-hour respite care may be reimbursed.

g. Respite services provided for a period exceeding 24 consecutive hours to three or more individuals who require nursing care because of a mental or physical condition must be provided by a health care facility licensed as described in Iowa Code chapter 135C.

h. Respite services shall not be provided simultaneously with other residential, nursing, or home health aide services provided through the medical assistance program.

78.34(6) *Counseling services.* Counseling services are face-to-face mental health and substance use disorder services provided to the member and caregiver by a mental health professional as defined in rule 441—24.1(225A) to facilitate home management of the member and prevent institutionalization. Counseling services are nonpsychiatric services necessary for the management of depression, assistance with the grief process, alleviation of psychosocial isolation and support in coping with a disability or illness, including terminal illness. Counseling services may be provided both for the purpose of training the member's family or other caregiver to provide care and for the purpose of helping the member and those caring for the member to adjust to the member's disability

or terminal condition. Counseling services may be provided to the member's caregiver only when included in the case plan for the member.

Payment will be made for individual and group counseling. A unit of individual counseling for the waiver member or the waiver member and the member's caregiver is 15 minutes. A unit of group counseling is 15 minutes. Payment for group counseling is based on the group rate divided by six, or, if the number of persons who comprise the group exceeds six, the actual number of persons who comprise the group.

78.34(7) *Attendant care service.* Attendant care services are service activities performed by a person to help a member with self-care tasks that the member would typically do independently if the member were otherwise able. Covered service activities are limited to the nonskilled activities listed in paragraph 78.34(7) "f" and the skilled activities listed in paragraph 78.34(7) "g." Covered service activities must be essential to the health, safety, and welfare of the member. Services may be provided in the absence of a parent or guardian if the parent or guardian has given advance direction for the service provision.

a. Service planning.

(1) The member, parent, guardian, or attorney in fact under a durable power of attorney for health care shall:

1. Select the individual or agency that will provide the components of the attendant care services.

2. Determine with the selected provider what components of attendant care services the provider shall perform, subject to confirmation by the service worker or case manager that those components are consistent with the assessment and are authorized covered services.

3. Complete, sign, and date an HCBS Attendant Care Agreement to indicate the frequency, scope, and duration of services (a description of each service component and the time agreed on for that component). The case manager or service worker and provider shall also sign the agreement.

4. Submit the completed agreement to the service worker or case manager. The agreement shall be part of the member's service plan and shall be kept in the member's records, in the provider's records, and in the service worker's or case manager's records. Any service component that is not listed in the agreement shall not be payable.

(2) Whenever a legal representative acts as a provider of attendant care as allowed by 441—paragraph 79.10(7) "b," the following apply:

1. The payment rate for the legal representative must be based on the skill level of the legal representative and may not exceed the median statewide reimbursement rate for the service unless the higher rate receives prior approval from the department;

2. The legal representative may not be paid for more than 40 hours of service per week; and

3. A contingency plan must be established in the member's service plan to ensure service delivery in the event the legal representative is unable to provide services due to illness or other unexpected event.

b. Supervision of skilled services. Skilled attendant care services shall be provided under the supervision of the member's physician or a licensed nurse or licensed therapist working under the direction of the member's physician. The licensed nurse or therapist shall:

- (1) Retain accountability for actions that are delegated.

- (2) Ensure appropriate assessment, planning, implementation, and evaluation.

- (3) Make on-site supervisory visits every two weeks with the service provider present.

c. Service documentation. The attendant care provider shall document evidence of compliance with the requirements of this chapter and rule 441—79.3(249A). The documentation or copies of the documentation must be maintained or be electronically accessible by the provider. Providers must use an electronic visit verification system that captures all documentation requirements of the Attendant Care Service Record or use a form prescribed by the department. Any service component that is not documented in accordance with rule 441—79.3(249A) will not be payable.

d. Role of guardian or attorney. If the member has a guardian or attorney in fact under a durable power of attorney for health care:

(1) The service worker's or case manager's service plan shall address how attendant care services will be monitored to ensure that the member's needs are being adequately met. If the guardian or attorney in fact is the service provider, the service plan shall address how the service worker or case manager shall oversee service provision.

(2) The guardian or attorney in fact shall sign the claim form in place of the member, indicating that the service has been provided as presented on the claim.

e. Service units and billing. A unit of service is 15 minutes provided by an agency. Each service shall be billed in whole units.

f. Nonskilled services. Covered nonskilled service activities are limited to help with the following activities:

- (1) Dressing.
- (2) Bathing, shampooing, hygiene, and grooming.
- (3) Access to and from bed or a wheelchair, transferring, ambulation, and mobility in general.
- (4) Toileting, including bowel, bladder, and catheter assistance (emptying the catheter bag, collecting a specimen, and cleaning the external area around the catheter).
- (5) Meal preparation, cooking, and assistance with feeding, not including the cost of meals themselves. Meal preparation and cooking shall be provided only in the member's home.
- (6) Housekeeping, laundry, and shopping essential to the member's health care at home.
- (7) Taking medications ordinarily self-administered, including those ordered by a physician or other qualified health care provider.
- (8) Minor wound care.
- (9) Going to or returning from a place of employment and job-related tasks while the member is on the job site. Transportation for the member and assistance with understanding or performing the essential job functions are not included in services.
- (10) Tasks, such as financial management and scheduling, that require cognitive or physical assistance.
- (11) Communication essential to the health and welfare of the member, through interpreting and reading services and use of assistive devices for communication.
- (12) Using transportation essential to the health and welfare of the member. The cost of the transportation is not included.

g. Skilled services. Covered skilled attendant care service activities are limited to help with the following activities:

- (1) Tube feedings of members unable to eat solid foods.
- (2) Intravenous therapy administered by a registered nurse.
- (3) Parenteral injections required more than once a week.
- (4) Catheterizations, continuing care of indwelling catheters with supervision of irrigations, and changing of Foley catheters when required.
- (5) Respiratory care including inhalation therapy and tracheotomy care or tracheotomy care and ventilator.
- (6) Care of decubiti and other ulcerated areas, noting and reporting to the nurse or therapist.
- (7) Rehabilitation services including but not limited to bowel and bladder training, range of motion exercises, ambulation training, restorative nursing services, respiratory care and breathing programs, reality orientation, reminiscing therapy, remotivation, behavior modification, and reteaching of the activities of daily living.
- (8) Colostomy care.
- (9) Care of uncontrolled medical conditions, such as brittle diabetes, and comfort care of terminal conditions.
- (10) Postsurgical nursing care.

(11) Monitoring medications requiring close supervision because of fluctuating physical or psychological conditions, e.g., antihypertensives, digitalis preparations, mood-altering or psychotropic drugs, or narcotics.

(12) Preparing and monitoring response to therapeutic diets.

(13) Recording and reporting of changes in vital signs to the nurse or therapist.

h. Excluded services and costs. Services, activities, costs and time that are not covered as attendant care include the following (not an exclusive list):

(1) Any activity related to supervising a member. Only direct services are billable.

(2) Any activity that the member is able to perform.

(3) Costs of food.

(4) Costs for the supervision of skilled services by the nurse or therapist. The supervising nurse or therapist may be paid from private insurance, Medicare, or other third-party payment sources, or may be paid as another Medicaid service, including early and periodic screening, diagnosis and treatment services.

(5) Exercise that does not require skilled services.

(6) Parenting or child care for or on behalf of the member.

(7) Reminders and cueing.

(8) Services provided simultaneously with any other similar service regardless of funding source, including other waiver services and state supplementary assistance in-home health-related care services.

(9) Transportation costs.

(10) Wait times for any activity.

78.34(8) *Interim medical monitoring and treatment services.* Interim medical monitoring and treatment (IMMT) services are monitoring and treatment of a medical nature requiring specially trained caregivers beyond what is normally available in a day care setting for medical needs that make alternative care unavailable, inadequate, or insufficient. IMMT services are not intended to provide day care but to supplement available resources. Services must be ordered by a physician.

a. Need for service. The member must be currently receiving home health agency services under rule 441—78.9(249A) and require medical assessment, medical monitoring, and regular medical intervention or intervention in a medical emergency during those services. The case manager must identify the need for IMMT services after evaluating the member's living environment, family and natural supports, ability to perform activities of daily living, and health care needs. The services must be needed:

(1) To allow the member's usual caregivers to be employed,

(2) During a search for employment by a usual caregiver,

(3) To allow for academic or vocational training of a usual caregiver,

(4) Due to the hospitalization of a usual caregiver for treatment for physical or mental illness, or

(5) Due to the death of a usual caregiver.

b. Service requirements. Interim medical monitoring and treatment services shall:

(1) Provide experiences for each member's social, emotional, intellectual, and physical development;

(2) Include comprehensive developmental care and any special services for a member with special needs; and

(3) Include medical assessment, medical monitoring, and medical intervention as needed on a regular or emergency basis. Medical intervention means the ability to assess the situation and contact the appropriate medical professional, not the direct application of medical care.

c. Interim medical monitoring and treatment services may include supervision while the member is being transported to and from school or work setting.

d. Limitations.

(1) A maximum of 12 hours of service is available per day.

(2) Covered services do not include a complete nutritional regimen.

(3) Interim medical monitoring and treatment services may not duplicate any regular Medicaid or waiver services provided under the state plan. Services under the state plan, including home health agency services under rule 441—78.9(249A), must be exhausted before IMMT services are accessed.

(4) Interim medical monitoring and treatment services shall be provided in the following settings that are approved by the department as integrated, community-based settings: the member's home; a registered child development home; a licensed child care center, residential care facility, or adult day care facility; or during the time when the member is being transported to and from school or work.

(5) The member-to-staff ratio shall not be more than six members to one staff person.

(6) The parent or guardian of the member shall be responsible for the usual and customary nonmedical cost of day care during the time in which the member is receiving IMMT services. Medical care necessary for monitoring and treatment is an allowable IMMT cost. If the cost of care goes above the usual and customary cost of day care services due to the member's medical condition, the costs above the usual and customary cost will be covered as IMMT services.

e. A unit of service is 15 minutes.

78.34(9) Home and vehicle modification. Covered home or vehicle modifications are physical modifications to the member's home or vehicle that directly address the member's medical or remedial need. Covered modifications must be necessary to provide for the health, welfare, or safety of the member and enable the member to function with greater independence in the home or vehicle.

a. Modifications that are necessary or desirable without regard to the member's medical or remedial need and that would be expected to increase the fair market value of the home or vehicle, such as furnaces, fencing, or adding square footage to the residence, are excluded except as specifically included below. Purchasing or leasing of a motorized vehicle is excluded. Home and vehicle repairs are also excluded.

b. Only the following modifications are covered:

- (1) Kitchen counters, sink space, cabinets, special adaptations to refrigerators, stoves, and ovens.
- (2) Bathtubs and toilets to accommodate transfer, special handles and hoses for shower heads, water faucet controls, and accessible showers and sink areas.
- (3) Grab bars and handrails.
- (4) Turnaround space adaptations.
- (5) Ramps, lifts, and door, hall and window widening.
- (6) Fire safety alarm equipment specific for disability.
- (7) Voice-activated, sound-activated, light-activated, motion-activated, and electronic devices directly related to the member's disability.
- (8) Vehicle lifts, driver-specific adaptations, remote-start systems, including such modifications already installed in a vehicle.
- (9) Keyless entry systems.
- (10) Automatic opening device for home or vehicle door.
- (11) Special door and window locks.
- (12) Specialized doorknobs and handles.
- (13) Plexiglas replacement for glass windows.
- (14) Modification of existing stairs to widen, lower, raise or enclose open stairs.
- (15) Motion detectors.
- (16) Low-pile carpeting or slip-resistant flooring.
- (17) Telecommunications device for the deaf or hard of hearing.
- (18) Exterior hard-surface pathways.
- (19) New door opening.
- (20) Pocket doors.
- (21) Installation or relocation of controls, outlets, switches.
- (22) Air conditioning and air filtering if medically necessary.
- (23) Heightening of existing garage door opening to accommodate modified van.
- (24) Bath chairs.

- c. A unit of service is the completion of needed modifications or adaptations.
- d. All modifications and adaptations shall be provided in accordance with applicable federal, state, and local building and vehicle codes.
- e. Services shall be performed following prior department approval of the modification as specified in 441—subrule 79.1(17) and a binding contract between the provider and the member.
- f. All contracts for home or vehicle modification shall be awarded through competitive bidding. The contract shall include the scope of work to be performed, the time involved, supplies needed, the cost, diagrams of the project whenever applicable, and an assurance that the provider has liability and workers' compensation coverage and the applicable permit and license.
- g. Service payment will be made to the enrolled home or vehicle modification provider. If applicable, payment will be forwarded to the subcontracting agency by the enrolled home or vehicle modification provider following completion of the approved modifications.
- h. Services shall be included in the member's service plan and shall exceed the Medicaid state plan services.
- i. Payment for home and vehicle modifications are limited to the service limitations published on the Iowa Medicaid fee schedule webpage.

78.34(10) *Personal emergency response or portable locator system.*

- a. A personal emergency response system is an electronic device that transmits a signal to a central monitoring station to summon assistance in the event of an emergency.
 - (1) The required components of the system are:
 - 1. An in-home medical communications transceiver.
 - 2. A remote, portable activator.
 - 3. A central monitoring station with backup systems staffed by trained attendants at all times.
 - 4. Current data files at the central monitoring station containing response protocols and personal, medical, and emergency information for each member.
 - (2) The service shall be identified in the member's service plan.
 - (3) A unit of service is a one-time installation fee or one month of service.
 - (4) Maximum units per state fiscal year will be the initial installation and 12 months of service.
- b. A portable locator system is an electronic device that transmits a signal to a monitoring device. The system allows a member to access assistance in the event of an emergency and allows law enforcement or the monitoring system provider to locate a member who is unable to request help or to activate a system independently. The member must be unable to access assistance in an emergency situation due to the member's age or disability.
 - (1) The required components of the portable locator system are:
 - 1. A portable communications transceiver or transmitter to be worn or carried by the member.
 - 2. Monitoring by the provider at a central location with response protocols and personal, medical, and emergency information for each member as applicable.
 - (2) The service shall be identified in the member's service plan.
 - (3) Payable units of service are purchase of equipment, an installation or set-up fee, and monthly fees.
 - (4) Maximum units per state fiscal year will be one equipment purchase, one installation or set-up fee, and 12 months of service.

78.34(11) *Home-delivered meals.* Home-delivered meals are meals prepared elsewhere and delivered to a member at the member's residence.

- a. Each meal shall ensure the member receives a minimum of one-third of the daily recommended dietary allowance as established by the Food and Nutrition Board of the National Research Council of the National Academies of Sciences, Engineering, and Medicine. The meal may also be a liquid supplement that meets the minimum one-third standard.
- b. When a restaurant provides the home-delivered meal, the member is required to have a nutritional consultation. The nutritional consultation includes contact with the restaurant to explain the dietary needs of the member and what constitutes the minimum one-third daily dietary allowance.

c. A unit of service is a meal (morning, noon, evening, or liquid supplement). Any maximum combination of any two meals (morning, noon, evening, or liquid supplement) is allowed per day. Duplication of a meal in any one day is not allowed. The number of approved meals (morning, noon, evening, or liquid supplement) is contained in the member's service plan.

d. The number of meals delivered for any morning, noon, evening, or liquid supplement meal cannot exceed the number of calendar days in a calendar month; nor can the number of delivered meals exceed the number of authorized days in a month. Meals billed in excess of the calendar days in a calendar month and those billed in excess of the number of authorized days in a month are subject to recoupment or denial of payment.

78.34(12) *Nutritional counseling.* Nutritional counseling services may be provided for a nutritional problem or condition of such a degree of severity that nutritional counseling beyond that normally expected as part of the standard medical management is warranted. A unit of service is 15 minutes.

78.34(13) *Consumer choices option.* The consumer choices option (CCO) provides a member with a flexible monthly individual budget that is based on the member's service needs. With the individual budget, the member shall have the authority to purchase goods and services to meet the member's assessed needs and may choose to employ providers of services and supports. The services, supports, and items that are purchased with an individual budget must be directly related to a member's assessed need or goal established in the member's service plan. The CCO is available to any member receiving the AIDS/HIV, brain injury, elderly, health and disability, intellectual disability, or physical disability waiver programs who has the ability and desire to perform all budget authority tasks identified in paragraph 78.34(13)"g" and employer authority tasks identified in paragraph 78.34(13)"h," or who delegates the budget or employer authority tasks identified in paragraph 78.34(13)"i." Components of this service are set forth below.

a. *Agreement.* As a condition of participating in the CCO, a member shall sign the HCBS Consumer Choices Informed Consent and Risk Agreement to document that the member has been informed of the responsibilities and risks of electing the CCO.

b. *Individual budget amount.* A monthly individual budget amount shall be established for each member based on the assessed needs of the member and based on the services and supports authorized in the member's service plan. The member shall be informed of the individual budget amount during the development of the service plan.

(1) Services that may be included in determining the individual budget amount for a member in the HCBS health and disability, elderly, AIDS/HIV, brain injury, and physical disability waivers are outlined in the HCBS Waiver Provider Manual as amended to July 1, 2026.

(2) The department will determine an average unit cost for each service outlined in the HCBS Provider Manual based on actual unit costs from the previous fiscal year plus a cost-of-living adjustment.

(3) In aggregate, costs for individual budget services shall not exceed the current costs of waiver program services. In order to maintain cost neutrality, the department will apply a utilization adjustment factor to the amount of service authorized in the member's service plan before calculating the value of that service to be included in the individual budget amount.

(4) The department will compute the utilization adjustment factor for each service by dividing the net costs of all claims paid for the service by the total of the authorized costs for that service, using at least 12 consecutive months of aggregate service data. The utilization adjustment factor will be no lower than 60 percent.

(5) Individual budgets for respite services will be computed based on the average cost for services outlined in the HCBS Provider Manual. Respite services are not subject to the utilization adjustment factor in subparagraph 78.34(13)"b"(3).

(6) Anticipated costs for home and vehicle modification, assistive devices, and specialized medical equipment are not subject to the average cost in subparagraph 78.34(13)"b"(2) or the utilization adjustment factor in subparagraph 78.34(13)"b"(3). The anticipated costs may include

the costs of the financial management services and the independent support broker when the home and vehicle modification, assistive device, or specialized medical equipment is the only service included in the CCO monthly budget and the total cost for the home and vehicle modification, assistive device, or specialized medical equipment, including the cost of the financial management services and the independent support broker, is approved by Iowa Medicaid or the MCO as the least costly option to meet the member's need. Costs for the home and vehicle modification, assistive device, or specialized medical equipment may be paid to the financial management services provider in a one-time payment. Before becoming part of the CCO monthly budget, all home and vehicle modifications, assistive device, and specialized medical equipment shall be identified in the member's service plan and authorized by the case manager or community-based case manager.

(7) The individual budget amount may be changed only at the first of the month and shall remain fixed for the entire month.

c. Required service components. To participate in the CCO, a member must choose to hire an independent support broker and must work with a financial management service that is enrolled as a Medicaid provider. Before hiring the independent support broker, the member shall receive the results of the background check conducted pursuant to 441—Chapter 119.

d. Optional service components. A member who elects the CCO may purchase the following goods, services and supports, which shall be provided in the member's home or at an integrated community setting:

(1) Self-directed personal care services. Self-directed personal care services are services that provide a range of assistance in activities of daily living and incidental activities of daily living that help the member remain in the home and community. These services must be identified in the member's service plan developed by the member's case manager or community-based case manager.

(2) Self-directed community supports and employment. Self-directed community supports and employment are services that support the member in developing and maintaining independence and community integration. These services must be identified in the member's service plan developed by the member's case manager or community-based case manager.

(3) Individual-directed goods and services. Individual-directed goods and services are services, equipment, or supplies not otherwise provided through the Medicaid program that address an assessed need or goal identified in the member's service plan. The item or service shall meet the following requirements:

1. Promote opportunities for community living and inclusion.
2. Increase independence or substitute for human assistance, to the extent the expenditures would otherwise be made for that human assistance.
3. Be accommodated within the member's budget without compromising the member's health and safety.
4. Be provided to the member or directed exclusively toward the benefit of the member.
5. Be the least costly to meet the member's needs.
6. Not be available through another source.

e. Development of the individual budget. The independent support broker shall assist the member in developing and implementing the member's individual budget. The individual budget shall include:

- (1) The costs of the financial management service.
- (2) The costs of the independent support broker. The independent support broker may be compensated for up to 6 hours of service for assisting with the implementation of the initial individual budget. The independent support broker shall not be paid for more than 30 hours of service for an individual member during a 12-month period without prior approval by the department.

(3) The costs of any optional service component chosen by the member as described in paragraph 78.34(13)“d.” At a minimum, the CCO monthly budget must include the purchase of self-directed personal care, individual-directed goods and services, or self-directed community supports and services needed to meet the amount of service authorized for use in CCO identified in the member's

service plan. After funds have been budgeted to meet the identified needs, remaining funds from the monthly budget amount may be used to purchase additional self-directed personal care, individual-directed goods and services, or self-directed community supports and services as allowed by the monthly budget. The additional self-directed personal care, individual-directed goods and services, or self-directed community supports and services may exceed the amount of service or supports authorized in the member's service plan. Items and services not covered by the individual budget are outlined in the HCBS Provider Manual.

(4) The costs of any approved home or vehicle modification, assistive device, or specialized medical equipment. When authorized, the budget may include an amount allocated for a home or vehicle modification, an assistive device, or specialized medical equipment. Before becoming part of the individual budget, all home and vehicle modifications, assistive devices, and specialized medical equipment shall be identified in the member's service plan and approved by Iowa Medicaid or the member's MCO. The authorized amount shall not be used for anything other than the specific modification, assistive device, or specialized medical equipment as outlined in the HCBS Provider Manual.

(5) Any amount set aside in a savings plan to reserve funds for the future purchase of self-directed personal care, individual-directed goods and services, or self-directed community supports and services as defined in paragraph 78.34(13)"d." The savings plan shall meet the requirements in paragraph 78.34(13)"f."

f. Savings plan. A member savings plan must be in writing and be approved before the start of the savings plan by the department for fee-for-service members or by the member's MCO for members in managed care. Budget amounts allocated to the savings plan must result from efficiencies in meeting the member's service needs identified in the member's service plan.

(1) The savings plan shall identify:

1. The specific goods, services, supports or supplies to be purchased through the savings plan.
2. The amount of the individual budget allocated each month to the savings plan.
3. The amount of the individual budget allocated each month to meet the member's identified service needs.
4. How the member's assessed needs will continue to be met through the individual budget when funds are placed in savings.
5. Specific time spans for accumulating the savings allocation, not to exceed the member's current service plan year end date.

(2) With the exception of funds allocated for respite care, the savings plan shall not include funds budgeted for direct services or supports that were not received. Funds from unused respite services may be allocated to the savings plan but shall not be used for anything other than future respite care.

(3) Funds allocated to a savings plan may be used to purchase additional self-directed personal care, individual-directed goods and services, or self-directed community supports and services. The additional self-directed personal care, individual-directed goods and services, or self-directed community supports and services included in the monthly budget may exceed the amount of service or supports authorized in the member's service plan. The self-directed personal care, individual-directed goods and services, or self-directed community supports and services purchased with funds from a savings plan must:

1. Be used to meet a member's identified need,
2. Be medically necessary, and
3. Be approved by the member's case manager or community-based case manager.

(4) All funds allocated to a savings plan to purchase additional self-directed personal care, individual-directed goods and services, or self-directed community supports and services must be used during the member's waiver year in which the saving occurred.

(5) The annual reassessment of a member's needs must take into account the purchases of goods and services that substitute for human assistance. Adjustments shall be made to the services used to determine the individual budget based on the reassessment.

g. *Budget authority.* The member shall have authority over the individual budget authorized by the department or MCO to perform the following tasks:

- (1) Contract with entities to provide services and supports as described in this subrule.
- (2) Determine the amount to be paid for services. Reimbursement rates for employees shall be consistent with employee reimbursement rates or the prevailing wages paid by others in the community for the same or substantially similar services. Reimbursement rates for the independent support broker and the financial management service are subject to the limits in 441—subrule 79.1(2).
- (3) Schedule the provision of services. A contingency plan must be established in the member's service plan to ensure service delivery in the event the member's employee is unable to provide services due to illness or other unexpected event.
- (4) Authorize payment for optional service components identified in the individual budget. When the member's guardian or legal representative is a paid employee, payment authorization for optional service components must be delegated to a representative pursuant to paragraph 78.34(13) "i."
- (5) Reallocate funds among services included in the budget. Every purchase of a good or service must be identified and approved in the individual budget before the purchase is made.

h. *Employer authority.* The member shall have the authority to be the common-law employer of employees providing services and support under the CCO. A common-law employer has the right to direct and control the performance of the services. If the member is a child, the parent or the legal representative shall be responsible for completing all employer authority tasks. Adult members who do not have the ability to complete all employer authority tasks shall have a representative delegated to complete the employer authority tasks identified in this paragraph. Documentation of the person responsible for the employer authority tasks, whether the member or another entity, shall be included in the member's service plan. The member or the delegated employer authority may perform the following functions:

- (1) Recruit and hire employees.
- (2) Verify employee qualifications.
- (3) Specify additional employee qualifications.
- (4) Determine employee duties.
- (5) Determine employee wages and benefits.
- (6) Schedule employees.
- (7) Train and supervise employees.

i. *Delegation of budget and employer authority.* The member may delegate responsibilities for the individual budget or employer authority functions to a representative. If the member is a child, the parent or the legal representative shall be delegated all budget and employer authority tasks. Adult members aged 18 and older who do not have the ability to complete all budget or employer authority tasks shall have a representative delegated to complete the applicable budget authority tasks identified in paragraph 78.34(13) "g" and employer authority tasks identified in paragraph 78.34(13) "h." Documentation of the person responsible for the budget and employer authority tasks, whether the member or a representative, shall be included in the member's service plan.

- (1) The representative must be at least 18 years old.
- (2) The representative shall not be a current provider of service to the member.
- (3) The member shall sign a consent form that designates who the member has chosen as a representative and the responsibilities of the representative.
- (4) The representative shall not be paid for this service.

j. *Employment agreement.* Any person employed by the member to provide services under the CCO shall sign an employment agreement with the member that outlines the employee's and member's responsibilities.

k. *Responsibilities of the independent support broker.* The independent support broker shall perform the following services as directed by the member or the member's representative:

- (1) Assist the member with developing the member's initial and subsequent individual budgets and with making any changes to the individual budget.

- (2) Have monthly contact with the member for the first four months of implementation of the initial individual budget and have, at a minimum, quarterly contact thereafter.
- (3) Complete the required employment packet with the financial management service.
- (4) Assist with interviewing potential employees and entities providing services and supports if requested by the member.
- (5) Assist the member with determining whether a potential employee meets the qualifications necessary to perform the job.
- (6) Assist the member with obtaining a signed consent from a potential employee to conduct background checks if requested by the member.
- (7) Assist the member with negotiating with entities providing services and supports if requested by the member.
- (8) Assist the member with contracts and payment methods for services and supports if requested by the member.
- (9) Assist the member with developing an emergency backup plan. The emergency backup plan shall address any health and safety concerns.
- (10) Review expenditure reports from the financial management service to ensure that services and supports in the individual budget are being provided.
- (11) Document in writing on the independent support broker timecard every contact the broker has with the member. Contact documentation shall include information on the extent to which the member's individual budget has addressed the member's needs and the satisfaction of the member.
 1. *Responsibilities of the financial management service.* The financial management service shall perform all of the following services:
 - (1) Receive Medicaid funds in an electronic transfer.
 - (2) Process and pay invoices for approved goods and services included in the individual budget.
 - (3) Monitor and track the approved individual budget amount authorized each month and document all expenditures as they are paid.
 - (4) Provide real-time individual budget account balances for the member, the independent support broker, and the department, available at a minimum during normal business hours (9 a.m. to 5 p.m., Monday through Friday).
 - (5) Conduct criminal background checks on potential employees pursuant to 441—Chapter 119.
 - (6) Verify for the member an employee's citizenship or alien status.
 - (7) Assist the member with fiscal and payroll-related responsibilities including but not limited to:
 1. Verifying that hourly wages comply with federal and state labor rules.
 2. Collecting and processing timecards.
 3. Withholding, filing, and paying federal, state and local income taxes, Medicare and Social Security (FICA) taxes, and federal (FUTA) and state (SUTA) unemployment and disability insurance taxes, as applicable.
 4. Computing and processing other withholdings, as applicable.
 5. Processing all judgments, garnishments, tax levies, or other withholding on an employee's pay as may be required by federal, state, or local laws.
 6. Preparing and issuing employee payroll checks.
 7. Preparing and disbursing IRS Forms W-2 and W-3 annually.
 8. Processing federal advance earned income tax credit for eligible employees.
 9. Refunding over-collected FICA, when appropriate.
 10. Refunding over-collected FUTA, when appropriate.
 - (8) Assist the member in completing required federal, state, and local tax and insurance forms.
 - (9) Establish and manage documents and files for the member and the member's employees.
 - (10) Monitor timecards, receipts, and invoices to ensure that they are consistent with the individual budget. Keep records of all timecards and invoices for each member for a total of five years.

(11) Provide to the department, the independent support broker, and the member monthly and quarterly status reports that include a summary of expenditures paid and amount of budget unused.

(12) Establish an accessible customer service system and a method of communication for the member and the independent support broker that includes alternative communication formats.

(13) Establish a customer services complaint reporting system.

(14) Develop a policy and procedures manual that is current with state and federal regulations and update as necessary.

(15) Develop a business continuity plan in the case of emergencies and natural disasters.

(16) Provide to the department an annual independent audit of the financial management service.

(17) Assist in implementing the state's quality management strategy related to the financial management service.

(18) The department may request that the financial management service provider withhold payment to any member or member's employee to offset any overpayment or enforce any sanction placed on the service provider pursuant to rule 441—79.3(249A).

m. Responsibilities of the member and the employee. A member participating in the CCO and the member's employee(s) are responsible for the following:

(1) A member participating in the CCO shall be jointly and severally liable with any of the member's employees for any overpayment of medical assistance funds used through a CCO budget.

(2) A member may not employ any person who has been sanctioned, or who is affiliated with a person or an entity that has been sanctioned, under 441—Chapter 79. For purposes of this subparagraph, "sanction" also includes anyone who has been temporarily suspended for a credible allegation of fraud under 42 CFR Part 455 as amended to July 1, 2026. Any CCO funds paid to any employee who or which has been sanctioned is an overpayment that the department shall recoup under 441—Chapter 79.

(3) A member may not employ any person who has been excluded by the Office of the Inspector General of the Department of Health and Human Services under Sections 1128 or 1156 of the Social Security Act as amended to July 1, 2026, and is not eligible to receive federal funds.

(4) For personal care services, employees shall use an electronic visit verification system that captures all documentation requirements of the Consumer Choices Option Semi-Monthly Time Sheet or use a form prescribed by the department. All other employees shall complete, sign and date the Consumer Choices Option Semi-Monthly Time Sheet, for each date of service provided to a member. All employees shall maintain documentation that complies with rule 441—79.3(249A).

(5) Members shall sign, and certify under penalty of perjury, each employee timecard identified in subparagraph 78.34(13)"m"(4) prior to the timecard's submission to the financial management service provider for payment in order to verify that all information on the submitted timecard accurately describes the amount, duration, and scope of services provided. When timecard information is submitted to the financial management service provider in an electronic format, the member shall retain the signed employee timecard for five years from the date of service.

78.34(14) General service standards. All health and disability waiver services must be provided in accordance with the following standards:

a. Reimbursement will not be available under the waiver for any services that the member can obtain as other nonwaiver Medicaid services or through any other funding source.

b. All services provided under the waiver must be delivered in the least restrictive environment possible and in conformity with the member's service plan.

c. All rights restrictions must be implemented in accordance with 441—subrule 77.30(4).

d. Services must be billed in whole units.

e. For all services with a 15-minute unit of service, the following rounding process will apply:

(1) Add together the minutes spent on all billable activities during a calendar day for a daily total.

(2) For each day, divide the total minutes spent on billable activities by 15 to determine the number of full 15-minute units for that day.

(3) Round the remainder using these guidelines: Round 1 to 7 minutes down to zero units; round 8 to 14 minutes up to one unit.

(4) Add together the number of full units and the number of rounded units to determine the total number of units to bill for that day.

[ARC 0315D, IAB 5/27/26, effective 7/1/26]

441—78.35(249A) Occupational therapist services. Payment will be approved for the services provided by an occupational therapist that follow a treatment plan established by the physician, nurse practitioner, clinical nurse specialist, or PA; are reasonable and necessary to the treatment of the patient's illness or injury; and meet the guidelines defined for restorative, maintenance, or trial therapy as set forth in paragraphs 78.19(1) "a" and "c."

[ARC 0315D, IAB 5/27/26, effective 7/1/26]

441—78.36(249A) Hospice services.

78.36(1) General characteristics. A hospice is a public agency or private organization or a subdivision of either that is primarily engaged in providing care to terminally ill individuals. A hospice provides palliative and supportive services to meet the physical, psychosocial, social and spiritual needs of a terminally ill individual and the individual's family or other persons caring for the individual regardless of where the individual resides. Hospice services are those services to control pain and provide support to individuals to continue life with as little disruption as possible.

a. Covered services. Covered services include, in accordance with Medicare guidelines, the following:

- (1) Nursing care.
- (2) Medical social services.
- (3) Physician services.
- (4) Counseling services provided to the terminally ill individual and the individual's family members or other persons caring for the individual at the individual's place of residence, including bereavement, dietary, and spiritual counseling.
- (5) Short-term inpatient care provided in a participating hospice inpatient unit or a participating hospital or nursing facility that additionally meets the special hospice standards regarding staffing and patient areas for pain control, symptom management and respite purposes.
- (6) Medical appliances and supplies, including drugs and biologicals, as needed for the palliation and management of the individual's terminal illness and related conditions, except for "covered Part D drugs" as defined by 42 U.S.C. Section 1395w-102(e)(1)-(2) as amended to July 1, 2026, for a "Part D eligible individual" as defined in 42 U.S.C. Section 1395w-101(a)(3)(A) as amended to July 1, 2026, including an individual who is not enrolled in a Part D plan.
- (7) Home maintenance support and home health aide services.
- (8) Physical therapy, occupational therapy and speech-language pathology unless this provision has been waived under the Medicare program for a specific provider.
- (9) Other items or services specified in the resident's plan that would otherwise be paid under the Medicaid program.

Nursing care, medical social services, and counseling are core hospice services and must routinely be provided directly by hospice employees. The hospice may contract with other providers to provide the remaining services. Bereavement counseling, consisting of counseling services provided after the individual's death to the individual's family or other persons caring for the individual, is a required hospice service but is not reimbursable.

b. Noncovered services.

(1) Covered services not related to the terminal illness. In accordance with Medicare guidelines, all medical services related to the terminal illness are the responsibility of the hospice. Services unrelated to the terminal illness are to be billed separately by the respective provider.

(2) Administrative duties performed by the medical director, any hospice-employed physician, or any consulting physician are included in the normal hospice rates. Patient care provided by

the medical director, hospice-employed physician, attending physician, or consulting physician is separately reimbursable. Payment to the attending or consulting physician includes other partners in practice.

(3) Hospice care provided by a hospice other than the hospice designated by the individual unless provided under arrangements made by the designated hospice.

(4) Curative antiviral drugs targeted at the human immunodeficiency virus for the treatment of AIDS.

78.36(2) *Categories of care.* Hospice care entails the following four categories of daily care. Guidelines for core and other services must be adhered to for all categories of care.

a. Routine home care is care provided in the place of residence that is not continuous.

b. Continuous home care is provided only during a period of crisis when an individual requires continuous care that is primarily nursing care to achieve palliation or management of acute medical symptoms. Nursing care must be provided by either a registered nurse or a licensed practical nurse and a nurse must be providing care for more than half of the period of care. A minimum of eight hours of care per day must be provided during a 24-hour day to qualify as continuous care. Home maintenance support and aide services may also be provided to supplement the nursing care.

c. Inpatient respite care is provided to the individual only when necessary to relieve the family members or other persons caring for the individual at home. Respite care may be provided only on an occasional basis and may not be reimbursed for more than five consecutive days at a time. Respite care may not be provided when the individual is a resident of a nursing facility.

d. General inpatient care is provided in periods of acute medical crisis when the individual is hospitalized or in a participating hospice inpatient unit or nursing facility for pain control or acute or chronic symptom management.

78.36(3) *Residence in a nursing facility.* For purposes of the Medicaid hospice benefit, a nursing facility can be considered the residence of a beneficiary. When the person does reside in a nursing facility, the requirement that the care of a resident of a nursing facility must be provided under the immediate direction of either the facility or the resident's personal physician does not apply if all of the following conditions are met:

a. The resident is terminally ill.

b. The resident has elected to receive hospice services under the Medicaid program from a Medicaid-enrolled hospice program.

c. The nursing facility and the Medicaid-enrolled hospice program have entered into a written agreement under which the hospice program takes full responsibility for the professional management of the resident's hospice care and the facility agrees to provide room and board to the resident.

78.36(4) *Approval for hospice benefits.* Payment will be approved for hospice services to individuals who are certified as terminally ill, that is, the individuals have a medical prognosis that their life expectancy is six months or less if the illness runs its normal course, and who elect hospice care rather than active treatment for the illness.

a. Physician certification process. The hospice must obtain certification that an individual is terminally ill in accordance with the following procedures:

(1) The hospice may obtain verbal orders to initiate hospice service from the medical director of the hospice or the physician member of the hospice interdisciplinary group and by the individual's attending physician (if the individual has an attending physician). The verbal order shall be noted in the patient's record. The verbal order must be given within two days of the start of care and be followed up in writing no later than eight calendar days after hospice care is initiated. The certification must include the statement that the individual's medical prognosis is that the individual's life expectancy is six months or less if the illness runs its normal course.

(2) When verbal orders are not secured, the hospice must obtain, no later than two calendar days after hospice care is initiated, written certification signed by the medical director of the hospice or the physician member of the hospice interdisciplinary group and by the individual's attending physician (if the individual has an attending physician). The certification must include the statement that the

individual's medical prognosis is that the individual's life expectancy is six months or less, if the illness runs its normal course.

(3) Hospice care benefit periods consist of up to two periods of 90 days each and an unlimited number of subsequent 60-day periods as elected by the individual. The medical director or a physician must recertify at the beginning of each benefit period that the individual is terminally ill.

b. Election procedures. Individuals who are dually eligible for Medicare and Medicaid must receive hospice coverage under Medicare.

(1) Election statement. An individual, or individual's representative, elects to receive the hospice benefit by filing an election statement, the Election of Medicaid Hospice Benefit form, or a Medicare election of hospice benefit form, with a particular hospice. The hospice may provide the individual with another election form to use provided the form includes the following information:

1. Identification of the hospice that will provide the care.
2. Acknowledgment that the recipient has been given a full understanding of hospice care.
3. Acknowledgment that the recipient waives the right to regular Medicaid benefits, except for payment to the regular physician and treatment for medical conditions unrelated to the terminal illness.

4. Acknowledgment that recipients are not responsible for copayment or other deductibles.
5. The recipient's Medicaid number.
6. The effective date of election.
7. The recipient's signature.

(2) Change of designation. An individual may change the designation of the particular hospice from which the individual elects to receive hospice care one time only.

(3) Effective date. An individual may designate an effective date for the hospice benefit that begins with the first day of the hospice care or any subsequent day of hospice care, but an individual may not designate an effective date that is earlier than the date that the election is made.

(4) Duration of election. The election to receive hospice care will be considered to continue until one of the following occurs:

1. The individual dies.
2. The individual or the individual's representative revokes the election.
3. The individual's situation changes so that the individual no longer qualifies for the hospice benefit.

4. The hospice elects to terminate the recipient's enrollment in accordance with the hospice's established discharge policy.

(5) Revocation. A Revocation of Medicaid Hospice Benefit form is completed when an individual or the individual's representative revokes the hospice benefit allowed under Medicaid. When an individual revokes the election of Medicaid coverage of hospice care, the individual resumes Medicaid coverage of the benefits waived when hospice care was elected.

[ARC 0315D, IAB 5/27/26, effective 7/1/26]

441—78.37(249A) HCBS elderly waiver services. Payment will be approved for the following services to members eligible for the HCBS elderly waiver services as established in 441—Chapter 83 and as identified in the member's service plan. Payment will only be made for services provided in integrated, community-based settings that support full access of members receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.

78.37(1) Adult day care services. Adult day care services are activities provided pursuant to subrule 78.34(3).

78.37(2) Personal emergency response or portable locator system. A personal emergency response or portable locator system are services provided pursuant to subrule 78.34(10).

78.37(3) Home health aide services. Home health aide services are personal or direct care services provided to the client which are not payable under Medicaid as set forth in rule 441—78.9(249A). A unit of service is a visit. Components of the service include:

- a. Observation and reporting of physical or emotional needs.
- b. Helping a client with bath, shampoo, or oral hygiene.
- c. Helping a client with toileting.
- d. Helping a client in and out of bed and with ambulation.
- e. Helping a client reestablish activities of daily living.
- f. Assisting with oral medications ordinarily self-administered and ordered by a physician.
- g. Performing incidental household services which are essential to the client's health care at home and are necessary to prevent or postpone institutionalization in order to complete a full unit of service.

78.37(4) Home maintenance support services. Home maintenance support services are activities provided pursuant to subrule 78.34(1).

78.37(5) Nursing care services. Nursing care services are an extension of the State Plan, are included in the plan of treatment approved by the physician, and are provided by licensed agency nurses to members in the home or community. The services are reasonable and necessary to the treatment of an illness or injury and include all nursing tasks recognized by the board of nursing. A unit of service is one visit. Nursing care service can pay for a maximum of eight nursing visits per month for intermediate level of care persons. There is no limit on the maximum visits for skilled level of care persons.

78.37(6) Respite care services. Respite care services are service activities provided pursuant to subrule 78.34(5).

78.37(7) Home-delivered meals. Home-delivered meals are meals provided pursuant to subrule 78.34(11).

78.37(8) Home and vehicle modification. Covered home or vehicle modifications are activities provided pursuant to subrule 78.34(9).

78.37(9) Senior companion. Senior companion services are nonmedical care supervision, oversight, and respite. Companions may assist with such tasks as meal preparation, laundry, shopping and light housekeeping tasks. This service cannot provide hands-on nursing or medical care. A unit of service is 15 minutes.

78.37(10) Attendant care service. Attendant care services are service activities performed pursuant to subrule 78.34(7).

78.37(11) CCO. The CCO is service activities provided pursuant to subrule 78.34(13).

78.37(12) Case management services. Case management services are services that assist Medicaid members who reside in a community setting or are transitioning to a community setting in gaining access to needed medical, social, educational, housing, transportation, vocational, and other appropriate services in order to ensure the health, safety, and welfare of the member. Case management is provided at the direction of the member and the interdisciplinary team established pursuant to 441—subrule 83.22(2).

a. Case management services shall be provided as set forth in rules 441—90.4(249A) through 441—90.7(249A).

b. Case management shall not include the provision of direct services by the case managers.

c. Payment for case management shall not be made until the member is enrolled in the waiver. Payment shall be made only for case management services performed on behalf of the member during a month when the member is enrolled.

78.37(13) Assisted living service. The assisted living service includes unanticipated and unscheduled personal care and supportive services that are furnished to waiver participants who reside in a homelike, noninstitutional setting. The service includes the 24-hour on-site response capability to meet unpredictable member needs as well as member safety and security through incidental

supervision. Assisted living service is not reimbursable if performed at the same time as any service included in an approved attendant care agreement.

- a. A unit of service is one day.
 - b. A day of assisted living service is billable only if both the following requirements are met:
 - (1) The member was present in the facility during that day's bed census.
 - (2) The assisted living provider has documented at least one assisted living service encounter for that day, in accordance with rule 441—79.3(249A). The documentation must include the member's response to the service. The documented assisted living service cannot also be an authorized attendant care service.

78.37(14) General service standards. All elderly waiver services must be provided in accordance with the following standards:

- a. Reimbursement shall not be available under the waiver for any services that the member can obtain as other nonwaiver Medicaid services or through any other funding source.
 - b. All services provided under the waiver must be delivered in the least restrictive environment possible and in conformity with the member's service plan.
 - c. All rights restrictions must be implemented in accordance with 441—subrule 77.30(4).
 - d. Services must be billed in whole units.
 - e. For all services with a 15-minute unit of service, the rounding process detailed in paragraph 78.31(14)“e” will apply.

[ARC 0315D, IAB 5/27/26, effective 7/1/26]

441—78.38(249A) HCBS AIDS/HIV waiver services. Payment will be approved for the following services to members eligible for the HCBS AIDS/HIV waiver services as established in 441—Chapter 83 and as identified in the member's service plan. Payment shall only be made for services provided in integrated, community-based settings that support full access of members receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.

78.38(1) Counseling services. Counseling services are face-to-face mental health services provided to the member and caregiver by a mental health professional as defined in rule 441—24.1(225A) to facilitate home management of the member and prevent institutionalization. Counseling services are nonpsychiatric services necessary for the management of depression, assistance with the grief process, alleviation of psychosocial isolation and support in coping with a disability or illness, including terminal illness. Counseling services may be provided both for the purpose of training the member's family or other caregiver to provide care, and for the purpose of helping the member and those caring for the member to adjust to the member's disability or terminal condition. Counseling services may be provided to the member's caregiver only when included in the case plan for the member.

Payment will be made for individual and group counseling. A unit of individual counseling for the waiver member or the waiver member and the member's caregiver is 15 minutes. A unit of group counseling is 15 minutes. Payment for group counseling is based on the group rate divided by six, or, if the number of persons who comprise the group exceeds six, the actual number of persons who comprise the group.

78.38(2) Home health aide services. Home health aide services are personal or direct care services provided to the client which are not payable under Medicaid as set forth in rule 441—78.9(249A). A unit of service is a visit. Components of the service are:

- a. Observation and reporting of physical or emotional needs.
 - b. Helping a client with bath, shampoo, or oral hygiene.
 - c. Helping a client with toileting.
 - d. Helping a client in and out of bed and with ambulation.

- e. Helping a client reestablish activities of daily living.
- f. Assisting with oral medications ordinarily self-administered and ordered by a physician.
- g. Performing incidental household services which are essential to the client's health care at home and are necessary to prevent or postpone institutionalization in order to complete a full unit of service.

78.38(3) Home maintenance support services. Home maintenance support services are service activities provided pursuant to subrule 78.34(1).

78.38(4) Nursing care services. Nursing care services are services provided by licensed agency nurses to clients in the home which are ordered by and included in the plan of treatment established by the physician. The services shall be reasonable and necessary to the treatment of an illness or injury and include: observation; evaluation; teaching; training; supervision; therapeutic exercise; bowel and bladder care; administration of medications; intravenous and enteral feedings; skin care; preparation of clinical and progress notes; coordination of services; and informing the physician and other personnel of changes in the patient's conditions and needs. A unit of service is a visit.

78.38(5) Respite care services. Respite care services are services provided pursuant to subrule 78.34(5).

78.38(6) Home-delivered meals. Home-delivered meals are meals provided pursuant to subrule 78.34(11).

78.38(7) Adult day care services. Adult day care services are activities provided pursuant to subrule 78.34(3).

78.38(8) Attendant care service. Attendant care services are service activities performed pursuant to subrule 78.34(7).

78.38(9) CCO. The CCO are service activities provided pursuant to subrule 78.34(13).

78.38(10) General service standards. All AIDS/HIV waiver services must be provided in accordance with the following standards:

- a. Reimbursement will not be available under the waiver for any services that the member can obtain as other nonwaiver Medicaid services or through any other funding source.
- b. All services provided under the waiver must be delivered in the least restrictive environment possible and in conformity with the member's service plan.
- c. All rights restrictions must be implemented in accordance with 441—subrule 77.30(4).
- d. Services must be billed in whole units.
- e. For all services with a 15-minute unit of service, the rounding process outlined in paragraph 78.34(14)“e” will apply.

[ARC 0315D, IAB 5/27/26, effective 7/1/26]

441—78.39(249A) Federally qualified health centers. Payment will be made for services as defined in Section 1905(a)(2)(C) of the Social Security Act as amended to July 1, 2026.

78.39(1) Utilization review. Utilization review will be conducted for Medicaid members who access more than 24 outpatient visits in any 12-month period from physicians, ARNPs, federally qualified health centers, other clinics, and emergency rooms.

78.39(2) Risk assessment. Risk assessment, using a Medicaid Prenatal Risk Assessment form, shall be completed at the initial visit during a Medicaid member's pregnancy.

a. If the risk assessment reflects a low-risk pregnancy, the assessment shall be completed again at approximately the twenty-eighth week of pregnancy.

b. If the risk assessment reflects a high-risk pregnancy, referral shall be made for enhanced services described in subrule 78.25(3).

78.39(3) Vaccines. In order to be paid for the administration of a vaccine covered under the VFC program, a federally qualified health center must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

[ARC 0315D, IAB 5/27/26, effective 7/1/26]

441—78.40(249A) ARNPs. Payment will be approved for services provided by ARNPs within their scope of practice and the limitations of state law, with the exception of services not payable to physicians under rule 441—78.1(249A) or otherwise not payable under any other applicable rule.

78.40(1) *Direct payment.* Payment will be made to ARNPs directly, without regard to whether the ARNP is employed by or associated with a physician, hospital, birth center, clinic, or other health care provider recognized under state law. An established protocol between a physician and the ARNP will not cause an ARNP to be considered auxiliary personnel of a physician, or an employee of a hospital, birth center, or clinic.

78.40(2) *Location of service.* Payment will be approved for services rendered in any location in which the ARNP is legally authorized to provide services under state law. The nurse practitioner shall have promptly available the necessary equipment and personnel to handle emergencies.

78.40(3) *Utilization review.* Utilization review will be conducted for Medicaid members who access more than 24 outpatient visits in any 12-month period from physicians, ARNPs, other clinics, and emergency rooms.

78.40(4) *Vaccines.* In order to be paid for the administration of a vaccine covered under the VFC program, an ARNP must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

78.40(5) *Prenatal risk assessment.* Risk assessment, using a Medicaid Prenatal Risk Assessment, shall be completed at the initial visit during a Medicaid member's pregnancy.

a. If the risk assessment reflects a low-risk pregnancy, the assessment shall be completed again at approximately the twenty-eighth week of pregnancy.

b. If the risk assessment reflects a high-risk pregnancy, referral shall be made for enhanced services described in subrule 78.25(3).

[ARC 0315D, IAB 5/27/26, effective 7/1/26]

441—78.41(249A) HCBS intellectual disability waiver services. Payment will be approved for the following services to members eligible for the HCBS intellectual disability waiver as established in 441—Chapter 83 and as identified in the member's service plan. Payment will only be made for services provided in integrated, community-based settings that support full access of members receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.

78.41(1) *Supported community living services.* Supported community living services are provided by the provider within the member's home and community, according to the individualized member need as identified in the service plan.

a. Available components of the service are personal care services, home skills training services, individual advocacy services, community skills training services, personal environment support services, transportation, and treatment services.

(1) Personal and home skills training services are activities that assist a member to develop or maintain skills for self-care, self-directedness, and care of the immediate environment.

(2) Individual advocacy is the act or process of representing the member's rights and interests in order to realize the rights to which the member is entitled and to remove barriers to meeting the member's needs.

(3) Community skills training services are activities that assist a member to develop or maintain skills allowing better participation in the community. Services shall focus on the following areas as they apply to the member being served:

1. Personal management skills training services are activities that assist a member to maintain or develop skills necessary to sustain the member in the physical environment and are essential to the management of the member's personal business and property. This includes self-advocacy skills. Examples of personal management skills are the ability to maintain a household budget, plan and

prepare nutritional meals, use community resources such as public transportation and libraries, and select foods at the grocery store.

2. Socialization skills training services are activities that assist a member to develop or maintain skills which include self-awareness and self-control, social responsiveness, community participation, social amenities, and interpersonal skills.

3. Communication skills training services are activities that assist a member to develop or maintain skills including expressive and receptive skills in verbal and nonverbal language and the functional application of acquired reading and writing skills.

(4) Personal and environmental support services are activities and expenditures provided to or on behalf of a member in the areas of personal needs in order to allow the member to function in the least restrictive environment.

(5) Transportation services are activities and expenditures designed to assist the member to travel from one place to another to obtain services or carry out life's activities. The services exclude transportation provided as nonemergency medical transportation pursuant to rule 441—78.13(249A).

(6) Treatment services are activities designed to assist the member to maintain or improve physiological, emotional and behavioral functioning and to prevent conditions that would present barriers to the member's functioning. Treatment services include physical or physiological treatment and psychotherapeutic treatment.

1. Physiological treatment includes medication regimens designed to prevent, halt, control, relieve, or reverse symptoms or conditions that interfere with the normal functioning of the human body. Physiological treatment shall be provided by or under the direct supervision of a certified or licensed health care professional.

2. Psychotherapeutic treatment means activities provided to assist a member in the identification or modification of beliefs, emotions, attitudes, or behaviors in order to maintain or improve the member's functioning in response to the physical, emotional, and social environment.

b. The supported community living services are intended to provide for the daily living needs of the member and shall be available as needed during any 24-hour period. Activities do not include those associated with vocational services, academics, day care, medical services, Medicaid case management or other case management. Services are individualized supportive services provided in a variety of community-based, integrated settings.

(1) Supported community living services shall be available at a daily rate to members for whom a provider has primary responsibility for supervision or structure during the month. This service will provide supervision or structure in identified periods when another resource is not available.

(2) Supported community living services shall be available at a 15-minute rate to members for whom a daily rate is not established.

(3) Intensive residential services are supported community living services provided 24 hours per day to members with a serious and persistent mental illness diagnosis residing in a designated intensive residential service home. To be eligible for supported community living intensive residential services, the member must meet the eligibility criteria in paragraph 78.27(7) "c."

(4) Supported community living services delivered through the remote supports modality must meet the requirements pursuant to the HCBS Waiver Provider Manual as amended to July 1, 2026.

(5) Supported community living services delivered in a host home by a subcontractor of the supported community living services agency must meet the requirements pursuant to HCBS Waiver Provider Manual as amended to July 1, 2026.

c. Services may be provided to a child or an adult. A maximum of four persons may reside in a living unit.

(1) A member may live within the home of the member's family or legal representative or in another typical community living arrangement.

(2) A member living with the member's family or legal representative is not subject to the maximum of four residents in a living unit.

(3) A member may not live in a licensed medical or health care facility or in a setting that is required to be licensed as a medical or health care facility.

d. A member aged 17 or under living in the home of the member's family, legal representative, or foster family shall receive services based on development of adaptive, behavior, or health skills. Duration of services shall be based on age-appropriateness and individual attention span.

e. Additional criteria for receiving supported community living services for transition-age youth 16 to 18 years of age.

(1) Members residing in the family home may receive supported community living services as needed, subject to the criteria set forth in this rule.

(2) Members residing outside of the family home may receive daily supported community living in a provider-owned or controlled setting when the following criteria are met:

1. The proposed living environment must meet HCBS setting requirements in accordance with 441—subrule 77.30(5).

2. All providers of the service setting being requested must meet the following additional safety and service requirements for serving youth under the age of 18:

- Members 16 to 18 years of age shall receive 24-hour site supervision and support.
- Members under the age of 18 may not reside in settings with individuals over the age of 21.
- The comprehensive service plan shall specifically identify educational services and supports for individuals who have not obtained a high school diploma or equivalent.
- For individuals who have obtained a high school diploma or equivalent, the comprehensive service plan shall include supported employment, additional training, or educational supports.

3. The member's parent or guardian has consented to supported community living services.

4. The member is able to pay room and board costs (funding sources may include but are not limited to supplemental security income, child support, adoptions subsidy, or private funds).

f. Youth under the age of 16 needing supported community living outside the family home must receive services in a licensed or certified residential-based supported community living setting.

g. Maintenance and room and board costs are not reimbursable.

h. Provider budgets shall reflect costs associated with members' specific support needs as determined necessary by the interdisciplinary team for each member. The specific support needs must be identified in the Medicaid case manager's service plan, and the provider must maintain records to support the expenditures.

i. A unit of service is:

(1) One full calendar day when a member receives on-site staff supervision for eight or more hours per day as an average over a calendar month and the member's service plan identifies and reflects the need for this amount of supervision.

(2) Fifteen minutes when subparagraph 78.41(1)“i”(1) does not apply.

j. The maximum number of units available per member is as follows:

(1) 365 daily units per state fiscal year, except a leap year, when 366 daily units are available.

(2) 20,440 15-minute units per state fiscal year, except a leap year, when 20,496 15-minute units are available.

k. The service shall be identified in the member's service plan.

l. Supported community living services will not be simultaneously reimbursed with other residential services or with respite, nursing, or home health aide services provided through Medicaid or the waiver.

78.41(2) *Respite care services.* Respite care services are services provided pursuant to subrule 78.34(5).

78.41(3) *Personal emergency response or portable locator system.* The personal emergency response or portable locator system are services provided pursuant to subrule 78.34(10).

78.41(4) *Home and vehicle modification.* Covered home or vehicle modifications are activities provided pursuant to subrule 78.34(9).

78.41(5) *Nursing services.* Nursing services are individualized in-home medical services provided by licensed nurses. Services shall exceed the Medicaid state plan services and be included in the member's individual comprehensive plan.

- a. A unit of service is one hour.
- b. A maximum of ten units are available per week.

78.41(6) *Home health aide services.* Home health aide services are personal or direct care services provided to the member that are not payable under Medicaid as set forth in rule 441—78.9(249A). Services shall include unskilled medical services and shall exceed those services provided under HCBS intellectual disability waiver supported community living. Instruction, supervision, support or assistance in personal hygiene, bathing, and daily living shall be provided under supported community living.

- a. Services shall be included in the member's service plan.
- b. A unit is one hour.
- c. A maximum of 14 units are available per week.

78.41(7) *Supported employment services.* Supported employment services are service activities provided pursuant to subrule 78.27(10).

78.41(8) *Attendant care service.* Attendant care services are service activities performed pursuant to subrule 78.34(7).

78.41(9) *IMMT services.* IMMT services are activities performed pursuant to subrule 78.34(8).

78.41(10) *Residential-based supported community living services.* Residential-based supported community living services are medical or remedial services provided to children under the age of 18 while living outside their home in a certified residential-based supported community living environment furnished by the residential-based supported community living service provider. The services eliminate barriers to family reunification or assist in developing self-help skills for maximum independence.

- a. Allowable service components are:

- (1) Daily living skills development. These are services to develop the child's ability to function independently in the community on a daily basis, including training in food preparation, maintenance of living environment, time and money management, personal hygiene, and self-care.

- (2) Social skills development. These are services to develop a child's communication and socialization skills, including interventions to develop a child's ability to solve problems, resolve conflicts, develop appropriate relationships with others, and develop techniques for controlling behavior.

- (3) Family support development. These are services necessary to allow a child to return to the child's family or another less restrictive service environment. These services must include counseling and therapy sessions that involve both the child and the child's family at least 50 percent of the time and that focus on techniques for dealing with the special care needs of the child and interventions needed to alleviate behaviors that are disruptive to the family or other group living unit.

- (4) Counseling and behavior intervention services. These are services to halt, control, or reverse stress and social, emotional, or behavioral problems that threaten or have negatively affected the child's stability. Activities under this service include counseling and behavior intervention with the child, including interventions to ameliorate problem behaviors.

- b. Residential-based supported community living services must also address the ordinary daily-living needs of the child, excluding room and board, such as needs for safety and security, social functioning, and other medical care.

- c. Residential-based supported community living services do not include services associated with vocational needs, academics, day care, Medicaid case management, other case management, or any other services that the child can otherwise obtain through Medicaid.

- d. Room and board costs are not reimbursable as residential-based supported community living services.

e. The scope of service shall be identified in the child's service plan pursuant to 441—paragraph 77.40(11)“d.”

f. Residential-based supported community living services will not be simultaneously reimbursed with other residential services provided under an HCBS waiver or otherwise provided under the Medicaid program.

g. A unit of service is a day. A day is 24 hours of supervision and support.

h. The maximum number of units of residential-based supported community living services available per child is 365 daily units per state fiscal year, except in a leap year when 366 daily units are available.

78.41(11) *Transportation.* Transportation services may be provided for members to conduct business errands and essential shopping, to travel to and from work or day programs, and to reduce social isolation. A unit of service is one mile of transportation or one one-way trip. Transportation may not be reimbursed when HCBS intellectual disability waiver daily supported community living service is authorized in a member's service plan.

78.41(12) *Adult day care services.* Adult day care services are activities provided pursuant to subrule 78.34(3).

78.41(13) *Prevocational services.* Prevocational services are service activities provided pursuant to subrule 78.27(9).

78.41(14) *Day habilitation.* Day habilitation services will be provided pursuant to subrule 78.27(8).

78.41(15) *CCO.* The CCO is service activities provided pursuant to subrule 78.34(13).

78.41(16) *General service standards.* All intellectual disability waiver services must be provided in accordance with the following standards:

a. Reimbursement will not be available under the waiver for any services the member can obtain as other nonwaiver Medicaid services or through any other funding source.

b. All services provided under the waiver must be delivered in the least restrictive environment possible and in conformity with the member's service plan.

c. All rights restrictions must be implemented in accordance with 441—subrule 77.30(4).

d. Services must be billed in whole units.

e. For all services with a 15-minute unit of service, the rounding process outlined in paragraph 78.34(14)“e” will apply.

[ARC 0315D, IAB 5/27/26, effective 7/1/26]

441—78.42(249A) Pharmacists providing covered vaccines. When the authorized pharmacist providing the vaccine meets all Iowa board of pharmacy expanded practice standards and Medicaid requirements, payment will be made for the following:

78.42(1) *Vaccines administered to children.* Payment will be made to an enrolled provider for an administration fee for vaccines available through the VFC program administered by the department if the provider is enrolled in the VFC program. Payment will be made for the vaccine cost only if the VFC program stock has been depleted.

78.42(2) *Vaccines administered to adults.* Payment will be made to an enrolled provider for an administration fee and vaccine cost.

78.42(3) *Verification and reporting.* Prior to the ordering and administration of an immunization pursuant to statewide protocol, the authorized pharmacist shall consult and review the Iowa Immunization Registry Information System (IRIS) or Iowa Health Information Network (IHIN). Within 30 calendar days following administration of any vaccine, the pharmacist shall report such administration to the patient's primary health care provider, primary physician, and IRIS or IHIN. If a patient does not have a primary health care provider, the pharmacist shall provide the patient with a written record of the vaccine administered to the patient and shall advise the patient to consult a physician.

[ARC 0315D, IAB 5/27/26, effective 7/1/26]

441—78.43(249A) HCBS brain injury waiver services. Payment will be approved for the following services to members eligible for the HCBS brain injury waiver services as established in 441—Chapter 83 and as identified in the member's service plan. Payment will only be made for services provided in integrated, community-based settings that support full access of members receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.

78.43(1) Case management services. Individual case management services means services that assist members who reside in a community setting or are transitioning to a community setting in gaining access to needed medical, social, educational, housing, transportation, vocational, and other appropriate services in order to ensure the health, safety, and welfare of the member.

a. Case management services shall be provided as set forth in rules 441—90.4(249A) through 441—90.7(249A).

b. The service shall be delivered in such a way as to enhance the capabilities of members and their families to exercise their rights and responsibilities as citizens in the community. The goal is to enhance the ability of the member to exercise choice, make decisions, take risks that are a typical part of life, and fully participate as members of the community.

c. The case manager must develop a relationship with the member so that the abilities, needs and desires of the member can be clearly identified and communicated and the case manager can help to ensure that the system and specific services are responsive to the needs of the individual members.

d. Members who are eligible for targeted case management are not eligible for case management as a waiver service.

78.43(2) Supported community living services. Supported community living services are provided by the provider within the member's home and community according to the individualized member need as identified in the service plan.

a. The basic components of the service may include but are not limited to personal and home skills training services, individual advocacy services, community skills training services, personal environment support services, transportation, and treatment services.

(1) Personal and home skills training services are activities that assist a member to develop or maintain skills for self-care, self-directedness, and care of the immediate environment.

(2) Individual advocacy is the act or process of representing the member's rights and interests in order to realize the rights to which the member is entitled and to remove barriers to meeting the member's needs.

(3) Community skills training services are activities that assist a member to develop or maintain skills allowing better participation in the community. Services shall focus on the following areas as they apply to the member being served:

1. Personal management skills training services are activities that assist a member to maintain or develop skills necessary to sustain the member in the physical environment and that are essential to the management of the member's personal business and property. This includes self-advocacy skills. Examples of personal management skills are the ability to maintain a household budget, plan and prepare nutritional meals, use community resources such as public transportation and libraries, and select foods at the grocery store.

2. Socialization skills training services are activities that assist a member to develop or maintain skills that include self-awareness and self-control, social responsiveness, community participation, social amenities, and interpersonal skills.

3. Communication skills training services are activities that assist a member to develop or maintain skills, including expressive and receptive skills in verbal and nonverbal language and the functional application of acquired reading and writing skills.

(4) Personal and environmental support services are those activities and expenditures provided to or on behalf of a member in the areas of personal needs in order to allow the member to function in the least restrictive environment.

(5) Transportation services are activities and expenditures designed to assist the member to travel from one place to another to obtain services or carry out life's activities. The services exclude transportation provided as nonemergency medical transportation pursuant to rule 441—78.13(249A).

(6) Treatment services are activities designed to assist the member to maintain or improve physiological, emotional and behavioral functioning and to prevent conditions that would present barriers to the member's functioning. Treatment services include physical or physiological treatment and psychotherapeutic treatment.

1. Physiological treatment includes medication regimens designed to prevent, halt, control, relieve, or reverse symptoms or conditions which interfere with the normal functioning of the human body. Physiological treatment shall be provided by or under the direct supervision of a certified or licensed health care professional.

2. Psychotherapeutic treatment means activities provided to assist a member in the identification or modification of beliefs, emotions, attitudes, or behaviors in order to maintain or improve the member's functioning in response to the physical, emotional, and social environment.

b. The supported community living services are intended to provide for the daily living needs of the member and shall be available as needed during any 24-hour period. Activities do not include those associated with vocational services, academics, day care, medical services, Medicaid case management or other case management. Services are individualized supportive services provided in a variety of community-based, integrated settings.

(1) Supported community living services shall be available at a daily rate to members living outside the home of their family, legal representative, or foster family and for whom a provider has primary responsibility for supervision or structure during the month. This service shall provide supervision or structure in identified periods when another resource is not available.

(2) Supported community living services shall be available at a 15-minute rate to members for whom a daily rate is not established.

c. Services may be provided to a child or an adult. Children must first access all other services for which they are eligible and that are appropriate to meet their needs before accessing the HCBS brain injury waiver services. A maximum of four persons may reside in a living unit.

(1) A member may live in the home of the member's family or legal representative or in another typical community living arrangement.

(2) A member living with the member's family or legal representative is not subject to the maximum of four residents in a living unit.

(3) A member may not live in a licensed medical or health care facility or in a setting that is required to be licensed as a medical or health care facility.

d. A member aged 17 or under living in the home of the member's family, legal representative, or foster family shall receive services based on development of adaptive, behavior, or health skills. Duration of services shall be based on age-appropriateness and individual attention span.

e. Provider budgets shall reflect all staff-to-member ratios and shall reflect costs associated with members' specific support needs for travel and transportation, consulting, instruction, and environmental modifications and repairs, as determined necessary by the interdisciplinary team for each member. The specific support needs must be identified in the Medicaid case manager's service plan, the total costs shall not exceed \$1,570 per member per year, and the provider must maintain records to support the expenditures. A unit of service is:

(1) One full calendar day when a member residing in the living unit receives on-site staff supervision for eight or more hours per day as an average over a calendar month and the member's service plan identifies and reflects the need for this amount of supervision.

(2) Fifteen minutes when subparagraph 78.43(2) "e"(1) does not apply.

f. The maximum number of units available per member is as follows:

- (1) 365 daily units per state fiscal year except a leap year, when 366 daily units are available.
- (2) 33,580 15-minute units per state fiscal year except a leap year, when 33,672 15-minute units are available.

g. The service shall be identified in the member's service plan.

h. Supported community living services shall not be simultaneously reimbursed with other residential services or with respite, transportation, personal assistance, nursing, or home health aide services provided through Medicaid or the HCBS brain injury waiver.

78.43(3) *Respite care services.* Respite care services are services provided to the member that give temporary relief to the usual caregiver and provide all the necessary care that the usual caregiver would provide during that period. The purpose of respite care is to enable the member to remain in the member's current living situation.

a. Services provided outside the member's home shall not be reimbursable if the living unit where respite is provided is reserved for another person on a temporary leave of absence.

b. Member-to-staff ratios shall be appropriate to the individual needs of the member as determined by the member's interdisciplinary team.

c. A unit of service is 15 minutes.

d. Respite care is not to be provided to members during the hours in which the usual caregiver is employed except when the member is attending a 24-hour residential camp. Respite care shall not be used as a substitute for a child's day care. Respite care cannot be provided to a member whose usual caregiver is an attendant care provider for the member.

e. The interdisciplinary team shall determine if the member will receive basic individual respite, specialized respite or group respite as defined in 441—Chapter 83.

f. A maximum of 14 consecutive days of 24-hour respite care may be reimbursed.

g. Respite services provided for a period exceeding 24 consecutive hours to three or more individuals who require nursing care because of a mental or physical condition must be provided by a health care facility licensed as described in Iowa Code chapter 135C.

h. Respite services shall not be provided simultaneously with other residential, supported community living services, nursing, or home health aide services provided through the medical assistance program.

78.43(4) *Supported employment services.* Supported employment services are service activities provided pursuant to subrule 78.27(10).

78.43(5) *Home and vehicle modification.* Covered home or vehicle modifications are activities provided pursuant to subrule 78.34(9).

78.43(6) *Personal emergency response or portable locator system.* A personal emergency response or portable locator system are services provided pursuant to subrule 78.34(10).

78.43(7) *Transportation.* Transportation services may be provided for members to conduct business errands and essential shopping, to travel to and from work or day programs, and to reduce social isolation. A unit of service is one mile of transportation or one one-way trip. Transportation may not be reimbursed simultaneously with HCBS brain injury waiver supported community living service when the transportation costs are included within the supported community living reimbursement rate.

78.43(8) *Specialized medical equipment.*

a. Specialized medical equipment includes medically necessary items that are for personal use by members with a brain injury and that:

- (1) Provide for health and safety of the member,
- (2) Are not ordinarily covered by Medicaid,
- (3) Are not funded by educational or vocational rehabilitation programs, and
- (4) Are not provided by voluntary means.

b. Coverage includes but is not limited to:

- (1) Electronic aids and organizers.
- (2) Medicine dispensing devices.

- (3) Communication devices.
- (4) Bath aids.
- (5) Noncovered environmental control units.
- (6) Repair and maintenance of items purchased through the waiver.
- c. Payment may be made to enrolled specialized medical equipment providers upon satisfactory receipt of the service not to exceed the service limitations published on the Iowa Medicaid fee schedule webpage.
- d. The need for specialized medical equipment shall be:
 - (1) Documented by a health care professional as necessary for the member's health and safety, and
 - (2) Identified in the member's service plan.
- e. Payment for most items will be based on a fee schedule. The amount of the fee will be determined as directed in 441—subrule 79.1(17).

78.43(9) *Adult day care services.* Adult day care services are activities provided pursuant to subrule 78.34(3).

78.43(10) *Family counseling and training services.* Family counseling and training services are face-to-face mental health services provided to the member and the family with whom the member lives, or who routinely provide care to the member to increase the member's or family members' capabilities to maintain and care for the member in the community. Counseling may include helping the member or the member's family members with crisis, coping strategies, stress reduction, management of depression, alleviation of psychosocial isolation and support in coping with the effects of a brain injury. It may include the use of treatment regimens as specified in the individual treatment plan. Periodic training updates may be necessary to safely maintain the member in the community.

Family may include spouse, children, friends, or in-laws of the member. Family does not include individuals who are employed to care for the member.

78.43(11) *Prevocational services.* Prevocational services are service activities provided pursuant to subrule 78.27(9).

78.43(12) *Behavioral programming.* Behavioral programming consists of individually designed strategies to increase the member's appropriate behaviors and decrease the member's maladaptive behaviors which have interfered with the member's ability to remain in the community. Behavioral programming includes:

- a. A complete assessment of both appropriate and maladaptive behaviors.
- b. Development of a structured behavioral intervention plan which should be identified in the individual treatment plan.

78.43(13) *Attendant care service.* Attendant care services are service activities performed pursuant to subrule 78.34(7).

78.43(14) *IMMT services.* IMMT services are activities performed pursuant to subrule 78.34(8).

78.43(15) *CCO.* The CCO is service activities provided pursuant to subrule 78.34(13).

78.43(16) *General service standards.* All brain injury waiver services must be provided in accordance with the following standards:

- a. Reimbursement will not be available under the waiver for any services that the member can obtain as other nonwaiver Medicaid services or through any other funding source.
- b. All services provided under the waiver must be delivered in the least restrictive environment possible and in conformity with the member's service plan.
- c. All rights restrictions must be implemented in accordance with 441—subrule 77.30(4).
- d. Services must be billed in whole units.
- e. For all services with a 15-minute unit of service, the rounding process outlined in paragraph 78.34(14)“e” will apply.

441—78.44(249A) Lead inspection services. Payment will be approved for lead inspection services. This service shall be provided for children who have had two venous blood lead levels of 15 to 19 micrograms per deciliter or one venous level greater than or equal to 20 micrograms per deciliter. This service includes, but is not limited to, X-ray fluorescence analyzer (XRF) readings, visual examination of paint, preventive education of the resident and homeowner, health education about lead poisoning, and a written report to the family, homeowner, medical provider, and local childhood lead poisoning prevention program.

[ARC 0315D, IAB 5/27/26, effective 7/1/26]

441—78.45(249A) Assertive community treatment. Assertive community treatment (ACT) services are comprehensive, integrated, and intensive outpatient services provided by a multidisciplinary team under the supervision of a psychiatrist. ACT services are directed toward the rehabilitation of behavioral, social, or emotional deficits or the amelioration of symptoms of a mental disorder. Most services are delivered in the member's home or another community setting.

78.45(1) Applicability. ACT services may be provided only to a member who meets all of the following criteria:

a. The member is at least 17 years old.
b. The member has a severe and persistent mental illness or complex mental health symptomatology. A severe and persistent mental illness is a psychiatric disorder that causes symptoms and impairments in basic mental and behavioral processes that produce distress and major functional disability in adult role functioning (such as social, personal, family, educational or vocational roles). Specifically, the member has a degree of impairment arising from a psychiatric disorder such that:

(1) The member does not have the resources or skills necessary to maintain an adequate level of functioning in the home or community environment without assistance or support;

(2) The member's judgment, impulse control, or cognitive perceptual abilities are compromised; and

(3) The member exhibits significant impairment in social, interpersonal, or familial functioning.

c. The member has a validated principal mental health diagnosis consistent with a severe and persistent mental illness. For this purpose, a mental health diagnosis means a disorder, dysfunction, or dysphoria diagnosed pursuant to the DSM, excluding neurodevelopmental disorders, substance-related disorders, personality disorders, medication-induced movement disorders and other adverse effects of medication, and other conditions that may be a focus of clinical attention. Members with a primary diagnosis of substance-related disorder, developmental disability, or organic disorder are not eligible for ACT services.

d. The member needs a consistent team of professionals and multiple mental health and support services to maintain the member in the community and reduce hospitalizations, as evidenced by:

(1) A pattern of repeated treatment failures with at least two hospitalizations within the previous 24 months, or

(2) A need for multiple or combined mental health and basic living supports to prevent the need for a more intrusive level of care.

e. The member presents a reasonable likelihood that ACT services will lead to specific, observable improvements in the member's functioning and assist the member in achieving or maintaining community tenure. Specifically, the member:

(1) Is medically stable;

(2) Does not require a level of care that includes more intensive medical monitoring;

(3) Presents a low risk to self, others, or property, with treatment and support; and

(4) Lives independently in the community or demonstrates a capacity to live independently and move from a dependent residential setting to independent living.

f. At the time of admission, the member has a comprehensive assessment that includes psychiatric history, medical history, work and educational history, substance use, problems with activities of daily living, social interests, and family relationships.

g. The member has a written treatment plan containing a work evaluation and the necessary psychiatric rehabilitation treatment and support services. The plan shall identify:

- (1) Treatment objectives and outcomes,
- (2) The expected frequency and duration of each service,
- (3) The location where the services will be provided,
- (4) A crisis plan, and
- (5) The schedule for updates of the treatment plan.

78.45(2) Services. The ACT team shall participate in all mental health services provided to the member and shall provide 24-hour service for the psychiatric needs of the member. Available ACT services are:

a. Evaluation and medication management.

(1) The evaluation portion of ACT services consists of a comprehensive mental health evaluation and assessment of the member by a psychiatrist, ARNP, or PA.

(2) Medication management consists of the prescription and management of medication by a psychiatrist, ARNP, or PA to respond to the member's complaints and symptoms. A psychiatric registered nurse assists in this management by contact with the member regarding medications and their effect on the member's complaints and symptoms.

b. Integrated therapy and counseling for mental health and substance use. This service consists of direct counseling for treatment of mental health and substance use symptoms by a psychiatrist, licensed mental health professional, ARNP, PA, or substance use specialist. Individual counseling is provided by other team members under the supervision of a psychiatrist or licensed mental health practitioner.

c. Skill teaching. Skill teaching consists of side-by-side demonstration and observation of daily living activities by a registered nurse, licensed mental health professional, psychologist, substance use counselor, peer specialist, community support specialist, ARNP, or PA.

d. Community support. Community support is provided by a licensed mental health professional, psychologist, substance use counselor, peer specialist, community support specialist, ARNP, or PA. Community support consists of the following activities focused on recovery and rehabilitation:

(1) Personal and home skills training to assist the member to develop and maintain skills for self-direction and coping with the living situation.

(2) Community skills training to assist the member in maintaining a positive level of participation in the community through development of socialization skills and personal coping skills.

e. Medication monitoring. Medication monitoring services are provided by a psychiatric nurse and other team members under the supervision of a psychiatrist or psychiatric nurse and consist of:

(1) Monitoring the member's day-to-day functioning, medication compliance, and access to medications; and

(2) Ensuring that the member keeps appointments.

f. Case management for treatment and service plan coordination. Case management consists of the development by the ACT team of an individualized treatment and service plan, including personalized goals and outcomes, to address the member's medical symptoms and remedial functional impairments.

(1) Case management includes:

1. Assessments, referrals, follow-up, and monitoring.

2. Assisting the member in gaining access to necessary medical, social, educational, and other services.

3. Assessing the member to determine service needs by collecting relevant historical information through member records and other information from relevant professionals and natural supports.

(2) The team shall:

1. Develop a specific care plan based on the assessment of needs, including goals and actions to address the needed medical, social, educational, and other necessary services.
 2. Make referrals to services and related activities to assist the member with the assessed needs.
 3. Monitor and perform follow-up activities necessary to ensure that the plan is carried out and that the member has access to necessary services. Activities may include monitoring contacts with providers, family members, natural supports, and others.
 4. Hold daily team meetings to facilitate ACT services and coordinate the member's care with other members of the team.
- g. *Crisis response.* Crisis response consists of direct assessment and treatment of the member's urgent or crisis symptoms in the community by a registered nurse, licensed mental health professional, psychologist, substance use counselor, community support specialist, case manager, ARNP, or PA, as appropriate.
- h. *Work-related services.* Work-related services may be provided by a registered nurse, licensed mental health professional, psychologist, substance use counselor, community support specialist, case manager, ARNP, or PA. Services consist of assisting the member in managing mental health symptoms as they relate to job performance. Services may include:
- (1) Collaborating with the member to look for job situations that may cause symptoms to increase and creating strategies to manage these situations.
 - (2) Assisting the member to develop or enhance skills to obtain a work placement, such as individual work-related behavioral management.
 - (3) Providing supports to maintain employment, such as crisis intervention related to employment.
 - (4) Teaching communication, problem solving, and safety skills.
 - (5) Teaching personal skills such as time management and appropriate grooming for employment.

[ARC 0315D, IAB 5/27/26, effective 7/1/26]

441—78.46(249A) Physical disability waiver service. Payment will be approved for the following services to members eligible for the HCBS physical disability waiver as established in 441—Chapter 83 and as identified in the member's service plan. Payment will only be made for services provided in integrated, community-based settings that support full access of members receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.

78.46(1) Attendant care service. Attendant care services are service activities performed pursuant to subrule 78.34(7).

78.46(2) Home and vehicle modification. Covered home or vehicle modifications are activities provided pursuant to subrule 78.34(9).

78.46(3) Personal emergency response or portable locator system. A personal emergency response or portable locator are services provided pursuant to subrule 78.34(10).

78.46(4) Specialized medical equipment. Specialized medical equipment are provided pursuant to subrule 78.43(8).

78.46(5) Transportation. Transportation services may be provided for members to conduct business errands and essential shopping, to travel to and from work or day programs, and to reduce social isolation. A unit of service is one mile of transportation or one one-way trip.

78.46(6) CCO. The CCO is service activities provided pursuant to subrule 78.34(13).

78.46(7) General service standards. All physical disability waiver services must be provided in accordance with the following standards:

- a. Reimbursement will not be available under the waiver for any services that the member can obtain as other nonwaiver Medicaid services or through any other funding source.

- b.* All services provided under the waiver must be delivered in the least restrictive environment possible and in conformity with the member's service plan.
- c.* All rights restrictions must be implemented in accordance with 441—subrule 77.30(4).
- d.* Services must be billed in whole units.
- e.* For all services with a 15-minute unit of service, the rounding process outlined in paragraph 78.34(14)“*e*” will apply.

[ARC 0315D, IAB 5/27/26, effective 7/1/26]

441—78.47(249A) Pharmaceutical case management services. Payment will be approved for pharmaceutical case management services provided by an eligible physician and pharmacist for Medicaid recipients determined to be at high risk for medication-related problems. These services are designed to identify, prevent, and resolve medication-related problems and improve drug therapy outcomes.

78.47(1) Medicaid recipient eligibility. Patients are eligible for pharmaceutical case management services if they have active prescriptions for four or more regularly scheduled nontopical medications, are ambulatory, do not reside in a nursing facility, and have at least one of the eligible disease states of congestive heart disease, ischemic heart disease, diabetes mellitus, hypertension, hyperlipidemia, asthma, depression, atrial fibrillation, osteoarthritis, gastroesophageal reflux, or chronic obstructive pulmonary disease.

78.47(2) Provider eligibility. Physicians and pharmacists shall meet the following criteria to provide pharmaceutical case management services.

a. Physicians and pharmacists must be enrolled in the Iowa Medicaid program, have an Iowa Medicaid provider number, and receive training under the direction of the department regarding the provision of pharmaceutical case management services under the Iowa Medicaid program.

A copy of pharmaceutical case management records, including documentation of services provided, shall be maintained on file in each provider's facility and be made available for audit by the department on request.

- b.* Physicians shall be licensed to practice medicine.
- c.* Pharmacists shall present to the department evidence of competency including state licensure, submit five acceptable patient care plans, and have successfully completed professional training on patient-oriented, medication-related problem prevention and resolution. Pharmacists shall also maintain problem-oriented patient records, provide a private patient consultation area, and submit a statement indicating that the submitted patient care plans are representative of the pharmacists' usual patient care plans.

Acceptable professional training programs are:

- (1) A doctor of pharmacy degree program.
- (2) The Iowa Center for Pharmaceutical Care (ICPC) training program, which is a cooperative training initiative of the University of Iowa College of Pharmacy, Drake University College of Pharmacy and Health Sciences, and the Iowa Pharmacy Foundation.
- (3) Other programs containing similar coursework and supplemental practice site evaluation and reengineering, approved by the department with input from a peer review advisory committee.

78.47(3) Services. Eligible patients may choose whether to receive the services. If patients elect to receive the services, they must receive the services from any eligible physician and pharmacist acting as a pharmaceutical case management (PCM) team. Usually the eligible physician and pharmacist will be the patient's primary physician and pharmacist. Pharmaceutical case management services are to be value-added services complementary to the basic medical services provided by the primary physician and pharmacist.

The PCM team shall provide the following services:

- a. Initial assessment.* The initial assessment shall consist of:
 - (1) A patient evaluation by the pharmacist, including:
 - 1. Medication history;

2. Assessment of indications, effectiveness, safety, and compliance of medication therapy;
3. Assessment for the presence of untreated illness; and
4. Identification of medication-related problems such as unnecessary medication therapy, suboptimal medication selection, inappropriate compliance, adverse drug reactions, and need for additional medication therapy.

(2) A written report and recommendation from the pharmacist to the physician.

(3) A patient care action plan developed by the PCM team with the patient's agreement and implemented by the PCM team. Specific components of the action plan will vary based on patient needs and conditions but may include changes in medication regimen, focused patient or caregiver education, periodic assessment for changes in the patient's condition, periodic monitoring of the effectiveness of medication therapy, self-management training, provision of patient-specific educational and informational materials, compliance enhancement, and reinforcement of healthy lifestyles. An action plan must be completed for each initial assessment.

b. New problem assessments. These assessments are initiated when a new medication-related problem is identified. The action plan is modified and new components are implemented to address the new problem. This assessment may occur in the interim between scheduled follow-up assessments.

c. Problem follow-up assessments. These assessments are based on patient need and a problem identified by a prior assessment. The patient's status is evaluated at an appropriate interval. The effectiveness of the implemented action plan is determined and modifications are made as needed.

d. Preventive follow-up assessments. These assessments occur approximately every six months when no current medication-related problems have been identified in prior assessments. The patient is reassessed for newly developed medication-related problems and the action plan is reviewed.

[ARC 0315D, IAB 5/27/26, effective 7/1/26]

441—78.48(249A) Public health agencies. Payments will be made to local public health agencies on a fee schedule basis for providing vaccine and vaccine administration and testing for communicable disease. In order to be paid for the administration of a vaccine covered under the VFC program, a public health agency must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

[ARC 0315D, IAB 5/27/26, effective 7/1/26]

441—78.49(249A) Infant and toddler program services. Subject to the following subrules, payment will be made for medical services provided to Medicaid eligible children by infant and toddler program providers under the infants and toddlers with disabilities program administered by the department, Iowa child health specialty clinics, and the department of education.

78.49(1) Covered services. Covered services include but are not limited to audiology, psychological evaluation and counseling, health and nursing services, nutrition services, occupational therapy services, physical therapy services, developmental services, speech-language services, vision services, case management, and medical transportation.

78.49(2) Case management services. Payment will also be approved for infant and toddler case management services subject to the following requirements:

a. Definition. "Case management" means services that will assist eligible children in gaining access to needed medical, social, educational, and other services. Case management is intended to address the complexities of coordinated service delivery for children with medical needs. The case manager should be the focus for coordinating and overseeing the effectiveness of all providers and programs in responding to the assessed need. Case management does not include the direct delivery of an underlying medical, educational, social, or other service to which an eligible child has been referred or any activities that are an integral part or an extension of the direct services.

b. Choice of provider. Children who also are eligible to receive targeted case management services under 441—Chapter 90 must choose whether to receive case management through the infant and toddler program or through 441—Chapter 90. The chosen provider must meet the requirements of this subrule.

(1) When a child resides in a medical institution, the institution is responsible for case management. The child is not eligible for any other case management services. However, noninstitutional case management services may be provided during the last 14 days before the child's planned discharge if the child's stay in the institution has been less than 180 consecutive days. If the child has been in the institution 180 consecutive days or longer, the child may receive noninstitutional case management services during the last 60 days before the child's planned discharge.

(2) If the case management agency also provides direct services, the case management unit must be designed so that conflict of interest is addressed and does not result in self-referrals.

(3) If the costs of any part of case management services are reimbursable under another program, the costs must be allocated between those programs and Medicaid in accordance with OMB Circular No. A-87 as amended to July 1, 2026, or any related or successor guidance or regulations regarding allocation of costs.

(4) The case manager must complete a competency-based training program with content related to knowledge and understanding of eligible children, Early ACCESS rules, the nature and scope of services in Early ACCESS, and the system of payments for services, as well as case management responsibilities and strategies. The department of education or its designee will determine whether a person has successfully completed the training.

c. Assessment. The case manager shall conduct a comprehensive assessment and periodic reassessment of an eligible child to identify all of the child's service needs, including the need for any medical, educational, social, or other services. Assessment activities are defined to include the following:

- (1) Taking the child's history;
- (2) Identifying the needs of the child;
- (3) Gathering information from other sources, such as family members, medical providers, social workers, and educators, if necessary, to form a complete assessment of the child;
- (4) Completing documentation of the information gathered and the assessment results; and
- (5) Repeating the assessment every six months to determine whether the child's needs or preferences have changed.

d. Plan of care. The case manager shall develop a plan of care based on the information collected through the assessment or reassessment. The plan of care shall:

- (1) Include the child's strengths and preferences;
- (2) Consider the child's physical and social environment;
- (3) Specify goals of providing services to the child; and
- (4) Specify actions to address the child's medical, social, educational, and other service needs. These actions may include activities such as ensuring the active participation of the child and working with the child or the child's authorized health care decision maker and others to develop goals and identify a course of action to respond to the assessed needs of the child.

e. Other service components. Case management must include the following components:

(1) Contacts with the child and family. The case manager shall have face-to-face contact with the child and family within the first 30 days of service and every three months thereafter. In months in which there is no face-to-face contact, a telephone contact between the service coordinator and the family is required.

(2) Referral and related activities to help a child obtain needed services. The case manager shall help to link the child with medical, social, or educational providers or other programs and services that are capable of providing needed services. Referral activities do not include provision of the direct services, program, or activity to which the child has been linked. Referral activities include:

1. Assisting the family in gaining access to the infant and toddler program services and other services identified in the child's plan of care.
2. Assisting the family in identifying available service providers and funding resources and documenting unmet needs and gaps in services.
3. Making referrals to providers for needed services.

4. Scheduling appointments for the child.
5. Facilitating the timely delivery of services.
6. Arranging payment for medical transportation.

(3) Monitoring and follow-up activities. Monitoring activities shall take place at least once annually for the duration of the child's eligibility, but may be conducted as frequently as necessary to ensure that the plan of care is effectively implemented and adequately addresses the needs of the child. Monitoring and follow-up activities may be with the child, family members, providers, or other entities. The purpose of these activities is to help determine:

1. Whether services are being furnished in accordance with the child's plan of care.
2. Whether the services in the plan of care are adequate to meet the needs of the child.
3. Whether there are changes in the needs or status of the child. If there are changes in the child's needs or status, follow-up activities shall include making necessary adjustments to the plan of care and to service arrangements with providers.

(4) Keeping records, including preparing reports, updating the plan of care, making notes about plan activities in the child's record, and preparing and responding to correspondence with the family and others.

f. Documentation of case management. For each child receiving case management, case records must document:

- (1) The name of the child;
- (2) The dates of case management services;
- (3) The agency chosen by the family to provide the case management services;
- (4) The nature, content, and units of case management services received;
- (5) Whether the goals specified in the care plan have been achieved;
- (6) Whether the family has declined services in the care plan;
- (7) Time lines for providing services and reassessment; and
- (8) The need for and occurrences of coordination with case managers of other programs.

78.49(3) *Child's eligibility.* Payable services must be provided to a child under the age of 36 months who is experiencing developmental delay or who has a condition that is known to have a high probability of resulting in developmental delay at a later date.

78.49(4) *Delivery of services.* Services must be delivered directly by the infant and toddler program provider or by a practitioner under contract with the infant and toddler program provider.

78.49(5) *Remission of nonfederal share of costs.* Payment for services shall be made only when the following conditions are met:

a. The infant and toddler program provider has executed an agreement to remit the nonfederal share of the cost to the department.

b. The infant and toddler program provider shall sign and return a Medicaid Billing Remittance form along with the funds remitted for the nonfederal share of the costs of the services specified on the form.

[ARC 0315D, IAB 5/27/26, effective 7/1/26]

441—78.50(249A) Local education agency services. Subject to the following subrules, payment will be made for medical services provided by local education agency services providers to Medicaid members under the age of 21.

78.50(1) *Covered services.* Covered services include but are not limited to audiology services, behavior services, consultation services, medical transportation, nursing services, nutrition services, occupational therapy services, personal assistance, physical therapy services, psychologist services, speech-language services, social work services, vision services, and school-based clinic visit services.

a. In order to be paid for the administration of a vaccine covered under the VFC program, a local education agency must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

b. Payment for supplies will be approved when the supplies are incidental to the patient's care, e.g., syringes for injections, and do not exceed \$25 per month. Durable medical equipment and other supplies are not covered as local education agency services.

c. To the extent that federal funding is not available under Title XIX of the Social Security Act as amended to July 1, 2026, payment for transportation between home and school is not a covered service.

78.50(2) *Delivery of services.* Services must be delivered directly by the local education agency services providers or by a practitioner under contract with the local education agency services provider.

78.50(3) *Remission of nonfederal share of costs.* Payment for services shall be made only when the following conditions are met:

a. The local education agency services provider has executed an agreement to remit the nonfederal share of the cost to the department.

b. The local education agency provider shall sign and return a Medicaid Billing Remittance form along with the funds remitted for the nonfederal share of the costs of the services as specified on the form.

[ARC 0315D, IAB 5/27/26, effective 7/1/26]

441—78.51(249A) Indian health service 638 facility services. Payment will be made for all medically necessary services and supplies provided by a licensed practitioner at an Indian health service 638 facility, as defined at rule 441—77.47(249A), within the practitioner's scope of practice and subject to the limitations and exclusions set forth in subrule 78.1(1).

[ARC 0315D, IAB 5/27/26, effective 7/1/26]

441—78.52(249A) HCBS children's mental health waiver services. Payment will be approved for the following services to members eligible for the HCBS children's mental health waiver as established in 441—Chapter 83 and as identified in the member's service plan. Payment will only be made for services provided in integrated, community-based settings that support full access of members receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.

78.52(1) *General service standards.* All children's mental health waiver services must be provided in accordance with the following standards:

a. Reimbursement will not be available under the waiver for any services that the member can obtain as other nonwaiver Medicaid services or through any other funding source.

b. All services provided under the waiver must be delivered in the least restrictive environment possible and in conformity with the member's service plan.

c. All rights restrictions must be implemented in accordance with 441—subrule 77.30(4).

d. Services must be billed in whole units.

e. For all services with a 15-minute unit of service, the rounding process outlined in paragraph 78.34(14)“e” will apply.

78.52(2) *Environmental modifications and adaptive devices.*

a. Environmental modifications and adaptive devices include medically necessary items installed or used within the member's home that are used by the member to address specific, documented health, mental health, or safety concerns. The following items are excluded under this service:

- (1) Items ordinarily covered by Medicaid.
- (2) Items funded by educational or vocational rehabilitation programs.
- (3) Items provided by voluntary means.
- (4) Repair and maintenance of items purchased through the waiver.
- (5) Fencing.

- b. A unit of service is one modification or device.
- c. For each unit of service provided, the case manager shall maintain in the member's case file a signed statement from a mental health professional on the member's interdisciplinary team that the service has a direct relationship to the member's diagnosis of serious emotional disturbance.
- d. Payment for most items will be based on a fee schedule. The amount of the fee will be determined as directed in 441—subrule 79.1(17).

78.52(3) *Family and community support services.* Family and community support services shall support the member and the member's family by the development and implementation of strategies and interventions that will result in the reduction of stress and depression and will increase the member's and the family's social and emotional strength.

a. Dependent on the needs of the member and the member's family members individually or collectively, family and community support services may be provided to the member, to the member's family members, or to the member and the family members as a family unit.

b. Family and community support services shall be provided under the recommendation and direction of a mental health professional who is a member of the member's interdisciplinary team pursuant to 441—Chapter 83.

c. Family and community support services shall incorporate recommended support interventions and activities, which may include the following:

- (1) Developing and maintaining a crisis support network for the member and for the member's family.
- (2) Modeling and coaching effective coping strategies for the member's family members.
- (3) Building resilience to the stigma of serious emotional disturbance for the member and the family.
- (4) Reducing the stigma of serious emotional disturbance by the development of relationships with peers and community members.
- (5) Modeling and coaching the strategies and interventions identified in the member's crisis intervention plan as defined in 441—24.1(225A) for life situations with the member's family and in the community.
- (6) Developing medication management skills.
- (7) Developing personal hygiene and grooming skills that contribute to the member's positive self-image.

(8) Developing positive socialization and citizenship skills.

d. Family and community support services may include an amount not to exceed \$1,500 per member per year for transportation within the community and purchase of therapeutic resources. Therapeutic resources may include books, training materials, and visual or audio media.

(1) The interdisciplinary team must have identified the transportation or therapeutic resource as a support need and included that need in the case manager's plan.

(2) The annual amount available for transportation and therapeutic resources must be listed in the member's service plan.

(3) The member's parent or legal guardian shall submit a signed statement that the transportation or therapeutic resource cannot be provided by the member or the member's family or legal guardian.

(4) The member's Medicaid case manager will maintain a signed statement that potential community resources are unavailable and will list the community resources contacted to fund the transportation or therapeutic resource.

(5) The transportation or therapeutic resource must not be otherwise eligible for Medicaid reimbursement.

e. The following components are specifically excluded from family and community support services:

- (1) Vocational services.
- (2) Prevocational services.
- (3) Supported employment services.

- (4) Room and board.
- (5) Academic services.
- (6) General supervision and care.
- f. A unit of family and community support services is 15 minutes.

78.52(4) *In-home family therapy.* In-home family therapy provides skilled therapeutic services to the member and family that will increase their ability to cope with the effects of serious emotional disturbance on the family unit and the familial relationships. The service must support the family by the development of coping strategies that will enable the member to continue living within the family environment.

- a. The goal of in-home family therapy is to maintain a cohesive family unit.
- b. In-home family therapy is exclusive of and cannot serve as a substitute for individual therapy, family therapy, or other mental health therapy that may be obtained through Medicaid or other funding sources.
- c. A unit of in-home family therapy service is 15 minutes.

78.52(5) *Respite care services.* Respite care services are services provided pursuant to subrule 78.34(5).

[ARC 0315D, IAB 5/27/26, effective 7/1/26]

441—78.53(249A) *Speech-language pathology services.* Payment will be approved for the same services provided by a speech-language pathologist that are payable under Title XVIII of the Social Security Act as amended to July 1, 2026 (Medicare).

[ARC 0315D, IAB 5/27/26, effective 7/1/26]

441—78.54(249A) *Services rendered via telehealth.* An in-person contact between a health care professional and a patient is not required as a prerequisite for payment for otherwise-covered services appropriately provided through telehealth in accordance with generally accepted health care practices and standards prevailing in the applicable professional community at the time the services are provided, as well as being in accordance with provisions under rule 481—655.9(147,148,272C). Health care services provided through in-person consultations or through telehealth shall be treated as equivalent services for the purposes of reimbursement.

[ARC 0315D, IAB 5/27/26, effective 7/1/26]

441—78.55(249A) *Community-based neurobehavioral rehabilitation services.* Payment will be made for community-based neurobehavioral rehabilitation services that do not duplicate other services covered in this chapter.

78.55(1) *Definitions.*

“Assessment” means the review of the current functioning of the member using the service in regard to the member’s situation, needs, strengths, abilities, desires, and goals.

“Brain injury” means a diagnosis in accordance with rule 441—83.81(249A).

“Health care” means the services provided by trained and licensed health care professionals to restore or maintain the member’s health.

“Intermittent community-based neurobehavioral rehabilitation services” are provided to a Medicaid member on an as-needed basis to support the member and the member’s family or caregivers to assist the member to increase adaptive behaviors, decrease maladaptive behaviors, and adapt and accommodate to challenging behaviors to support the member to remain in the member’s own home and community.

“Member” means a person who has been determined to be eligible for Medicaid under 441—Chapter 75.

“Neurobehavioral rehabilitation” refers to a specialized category of neurorehabilitation provided by a multidisciplinary team that has been trained in, and delivers, services individually designed to address cognitive, medical, behavioral and psychosocial challenges, as well as the physical manifestations of acquired brain injury. Services concurrently work to optimize functioning at

personal, family and community levels, by supporting the increase of adaptive behaviors, decrease of maladaptive behaviors and adaptation and accommodation to challenging behaviors to support a member to maximize the member's independence in activities of daily living and ability to live in the member's home and community.

"Program" means a set of related resources and services directed to the accomplishment of a fixed set of goals for eligible members.

"Standardized assessment" means a valid, reliable, and comprehensive functional assessment tool(s) or process, or both, approved by the department for use in the assessment of a member's individual needs.

78.55(2) Member eligibility. To be eligible to receive community-based neurobehavioral rehabilitation services, a member shall meet the following criteria:

a. Brain injury diagnosis. To be eligible for community-based neurobehavioral rehabilitation services, the member must have a brain injury diagnosis as set forth in rule 441—83.81(249A).

b. Risk factors. The member has the following post-brain injury risk factors:

(1) The member is exhibiting neurobehavioral symptoms in such frequency or severity that the member has undergone or is currently undergoing treatment more intensive than outpatient care and is currently hospitalized, institutionalized, incarcerated or homeless or is at risk of hospitalization, institutionalization, incarceration or homelessness; or

(2) The member has a history of presenting with neurobehavioral or psychiatric symptoms resulting in at least one episode that required professional supportive care more intensive than outpatient care more than once in a lifetime (e.g., emergency services, alternative home care, partial hospitalization, or inpatient hospitalization).

c. Need for assistance. The member exhibits neurobehavioral symptoms in such frequency, severity or intensity that community-based neurobehavioral rehabilitation is required.

d. Needs assessment. The member shall have an assessment of need completed prior to admission. The member shall have the Mayo-Portland Adaptability Inventory (MPAI) assessment as amended to July 1, 2026, completed by a qualified trained assessor. The assessment of need shall document the member's need for community-based neurobehavioral rehabilitation, and Iowa Medicaid or the member's MCO has determined that the member is in need of specialty neurobehavioral rehabilitation services.

e. Standards for assessment. Each member will have had the MPAI assessment completed within the 90 days prior to admission. In addition to the functional assessment, the needs assessment will have been completed and will include the assessment of a member's individual physical, emotional, cognitive, medical and psychosocial residuals related to the member's brain injury and must include the following:

(1) Identification of the neurobehavioral needs that put the member at risk, including but not limited to verbal aggression, physical aggression, self-harm, unwanted sexual behavior, cognitive and or behavioral perseveration, wandering or elopement, lack of motivation, lack of initiation or other unwanted social behaviors not otherwise specified.

(2) Identification of triggers of unwanted behaviors and the member's ability to self-manage the member's symptoms.

(3) The member's rehabilitation and medical care history to include medication history and status.

(4) The member's employment history and the member's barriers to employment.

(5) The member's dietary and nutritional needs.

(6) The member's community accessibility and safety.

(7) The member's access to transportation.

(8) The member's history of substance use.

(9) The member's vulnerability to exploitation and history of risk of exploitation.

(10) The member's history and status of relationships, natural supports and socialization.

f. Emergency admission. In the event that emergency admission is required, the assessment shall be completed within ten calendar days of admission.

78.55(3) Covered services.

a. Service setting.

(1) Community-based neurobehavioral residential rehabilitation services are provided to a member living in a three-to-five-bed residential care facility with a specialized license designation issued by the department of inspections, appeals, and licensing; or

(2) Community-based neurobehavioral intermittent rehabilitation services are provided to a member living in the member's own residence in the community.

No payment shall be made for community-based neurobehavioral rehabilitation when provided in a medical institution such as an ICF/ID, nursing facility or skilled nursing facility.

b. Community-based neurobehavioral rehabilitation residential services identified in the treatment plan may include:

- (1) Prescriptive programming to maintain and advance progress made in rehabilitation;
- (2) Modifying or adapting the member's environment to improve overall functioning;
- (3) Assistance in obtaining preventative, appropriate and timely medical and dental care;
- (4) Compensatory strategies to assist in managing ADLs;
- (5) Assistance with coordinating and obtaining physical, oral, or mental health care and any other professional services necessary to the member's health and well-being;
- (6) Behavioral and cognitive programming and supports;
- (7) Medication management and consultation with pharmacy;
- (8) Health and wellness management including dietary and nutritional programming;
- (9) Progressive physical strengthening, fitness and retraining;
- (10) Assistance with obtaining and use of assistive technology;
- (11) Sobriety support development;
- (12) Assistance with the self-identification of antecedent triggers;
- (13) Assistance with preparation for transition to less intensive services including accessing the community;
- (14) Flexibility in programming to meet individual needs;
- (15) Assistance with re-learning coping and compensatory strategies;
- (16) Support and assistance in seeking substance use and co-occurring disorders services;
- (17) Support and assistance with obtaining legal consultation and services;
- (18) Assistance with community accessibility and safety;
- (19) Assistance with re-learning household maintenance;
- (20) Assistance with recreational and leisure skill development;
- (21) Assistance with the development and application of self-advocacy skills to navigate the service system;
- (22) Opportunities to learn about brain injury and individual needs following brain injury;
- (23) Support for carrying out the member's individual goals in the rehabilitation treatment plan;
- (24) Assistance with pursuit of education and employment goals;
- (25) Protective oversight in the residential setting and community;
- (26) Assistance and education to family, providers and other support system interests that are supporting the member receiving neurobehavioral rehabilitation services;
- (27) Transitional support and training;
- (28) Transportation essential to the attainment of the member's individual goals in the rehabilitation treatment plan;
- (29) Promotion of a program structure and support for members served so they can relearn or regain skills for maximum independence, community access, and integration.

c. Community-based neurobehavioral rehabilitation intermittent services identified in the treatment plan may occur in the member's own home with or on behalf of the member and may include:

- (1) Promotion of a program structure and support for members served so they can re-learn or regain skills for maximum community inclusion and access;
- (2) Modifying or adapting the member's environment to improve overall functioning;
- (3) Compensatory strategies to assist in managing ADLs;
- (4) Behavioral supports;
- (5) Assistance with obtaining and use of assistive technology;
- (6) Assistance with the self-identification of antecedent triggers;
- (7) Flexibility in programming to meet the member's individual needs;
- (8) Assistance with re-learning coping and compensatory strategies;
- (9) Assistance with the development and application of self-advocacy skills to navigate the service system;
- (10) Support for carrying out the member's individual goals in the rehabilitation treatment plan;
- (11) Assistance and education to family, providers and other support system interests that are supporting the member receiving community-based neurobehavioral rehabilitation services;
- (12) Transitional support and training;
- (13) Transportation essential to the attainment of the member's individual goals in the rehabilitation treatment plan.

d. Approval of treatment plan. The community-based neurobehavioral services provider shall submit the proposed plan of care, the results of the member's formal assessment, and medical documentation supporting a brain injury diagnosis to Iowa Medicaid for approval before providing the services.

e. Initial treatment plan. Within 30 days of admission, the provider shall submit the member's treatment plan to Iowa Medicaid.

- (1) Iowa Medicaid will approve the provider's treatment plan if:
 1. The treatment plan conforms to the medical necessity requirements in subrule 78.55(4);
 2. The treatment plan is consistent with the written diagnosis and treatment recommendations made by a licensed medical professional that is a licensed neuropsychologist or neurologist, M.D., or D.O.;
 3. The treatment plan is sufficient in amount, duration, and scope to reasonably achieve its purpose;
 4. The provider can demonstrate that the provider possesses the skills and resources necessary to implement the plan; and
 5. The treatment plan does not exceed 180 days in duration.

(2) A treatment summary detailing the member's response to treatment during the previous approval period must be submitted when approval for subsequent plans is requested.

f. Subsequent plans. Iowa Medicaid may approve a subsequent neurobehavioral rehabilitation treatment plan that conforms to the conditions of medical necessity pursuant to subrule 78.55(4) and to the conditions pursuant to subrule 78.55(3).

- g.* Quality review. Iowa Medicaid may perform the quality review to evaluate:
- (1) The time elapsed from referral to rehabilitation treatment plan development;
 - (2) The continuity of treatment;
 - (3) The length of stay per member;
 - (4) The affiliation of the medical professional recommending services with the neurobehavioral rehabilitation services provider;
 - (5) Gaps in service;
 - (6) The results achieved;
 - (7) Member and stakeholder satisfaction;
 - (8) The provider's compliance with standards listed in rule 441—77.53(249A).

78.55(4) Medical necessity. Nothing in this rule will be deemed to exempt coverage of community-based neurobehavioral rehabilitation services from the requirement that services be medically necessary. "Medically necessary" means that the service is:

- a. Consistent with the diagnosis and treatment of the member's condition;
- b. Required to meet the medical needs of the member and is needed for reasons other than the convenience of the member or the member's caregiver;
- c. The least costly type of service that can reasonably meet the medical needs of the member; and
- d. In accordance with the standards of good medical practice. The standards of good practice for each field of medical and remedial care covered by the Iowa Medicaid program are those standards of good practice identified by:
 - (1) Knowledgeable Iowa clinicians practicing or teaching in the field; and
 - (2) The professional literature regarding best practices in the field.

78.55(5) *Documentation standards.* Community-based neurobehavioral rehabilitation service providers shall maintain service provision records, financial records, and clinical records in accordance with the provisions of rule 441—79.3(249A).

[ARC 0315D, IAB 5/27/26, effective 7/1/26]

441—78.56(249A) Child care medical services. Payments will be made to licensed child care centers that provide medical services in addition to child care. Medically necessary services are provided under a plan of care that is developed by licensed professionals within their scope of practice and authorized by the member's physician. The services include and implement a comprehensive protocol of care that is developed in conjunction with the parent or guardian and specifies the medical, nursing, personal care, psychosocial and developmental therapies required by the medically dependent or technologically dependent child served.

78.56(1) Nursing services are services that are provided by a registered nurse or a licensed practical nurse under the direction of the member's physician to a member in a licensed child care center. Nursing services shall be provided according to a written plan of care authorized by a physician. Payment for nursing services may be approved if the services are determined to be medically necessary as defined in subrule 78.56(5). Nursing services include activities that require the expertise of a nurse, such as physical assessment, tracheostomy care, medication administration, and tube feedings.

78.56(2) Personal care services are those services that are provided by an aide but are delegated and supervised by a registered nurse under the direction of the member's physician. Payment for personal care services may be approved if the services are determined to be medically necessary as defined in subrule 78.56(5). Personal care services shall be in accordance with the member's plan of care and authorized by a physician. Personal care services include the activities of daily living, oral hygiene, grooming, toileting, feeding, range of motion and positioning, and training the member in necessary self-help skills, including teaching prosocial skills and reinforcing positive interactions.

78.56(3) Psychosocial services are those services that focus at decreasing or eliminating maladaptive behaviors. Payment for psychosocial services may be approved if the services are determined to be medically necessary as defined in subrule 78.56(5). Psychosocial services shall be in accordance with the member's plan of care and authorized by a physician. Psychosocial services include implementing a plan using clinically accepted techniques for decreasing or eliminating maladaptive behaviors. Psychosocial intervention plans must be developed and reviewed by licensed mental health providers.

78.56(4) Developmental therapies are those services that are provided by an aide but are delegated and supervised by a licensed therapist under the direction of the member's physician. Payment for developmental therapies may be approved if the services are determined to be medically necessary as defined in subrule 78.56(5). Developmental therapies shall be in accordance with the member's plan of care and authorized by a physician. Developmental therapies include activities based on the individual's needs such as fine motor, gross motor, and receptive expressive language.

78.56(5) "Medically necessary" means the service is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent the worsening of conditions that endanger life, cause pain, result in

illness or infirmity, or threaten to cause or aggravate a disability or chronic illness and is an effective course of treatment for the member requesting a service.

78.56(6) Requirements.

a. Nursing, psychosocial, developmental therapies and personal care services shall be ordered in writing.

b. Nursing, psychosocial, developmental therapies and personal care services shall be authorized by the department or the department's designated review agent prior to payment.

c. Prior authorization shall be requested at the time of initial submission of the plan of care or at any time the plan of care is substantially amended and shall be renewed with the department or the department's designated review agent. Initial request for and request for renewal of prior authorization shall be submitted to the department's designated review agent. The provider of the service is responsible for requesting prior authorization and for obtaining renewal of prior authorization. The request for prior authorization shall include a nursing assessment, the plan of care, and supporting documentation. A treatment plan shall be completed prior to the start of care and at a minimum reviewed every 180 days thereafter. The plan of care shall support the medical necessity and intensity of services to be provided by reflecting the following information:

- (1) Place of service.
- (2) Type of service to be rendered and the treatment modalities being used.
- (3) Frequency of the services.
- (4) Assistance devices to be used.
- (5) Date on which services were initiated.
- (6) Progress of member in response to treatment.
- (7) Medical supplies to be furnished.
- (8) Member's medical condition as reflected by the following information, if applicable:
 1. Dates of prior hospitalization.
 2. Dates of prior surgery.
 3. Date last seen by a primary care provider.
 4. Diagnoses and dates of onset of diagnoses for which treatment is being rendered.
 5. Prognosis.
 6. Functional limitations.
 7. Vital signs reading.
 8. Date of last episode of acute recurrence of illness or symptoms.
 9. Medications.
- (9) Discipline of the person providing the service.
- (10) Certification period.
- (11) Physician's signature and date. The treatment plan must be signed and dated by the physician before the claim for service is submitted for reimbursement.
- (12) The appropriate department form is utilized during the prior authorization review.

78.56(7) Nursing, personal care, and psychosocial services do not include:

- a.* Services provided to members aged 21 and older.
- b.* Services that require prior authorizations that are provided without regard to the prior authorization process.
- c.* Nursing services provided simultaneously with other Medicaid services (e.g., home health aide, physical, occupational, or speech therapy services, etc.).
- d.* Services that exceed the services that are approvable under the private duty nursing and personal care program pursuant to subrule 78.9(10).
- e.* Transportation services.
- f.* Services provided to a member while the member is in institutional care.

441—78.57(249A) Qualified Medicare beneficiary (QMB) provider services.

78.57(1) Payment. Payment will be made to QMB providers for a QMB-eligible member's coinsurance, copayment, and deductible for Medicare-covered services. The eligible member may be responsible for copayments pursuant to 441—subrule 79.1(13).

78.57(2) Definitions.

“Coinsurance” means a percentage of costs of a covered health care service that has to be paid.

“Copayment” means a fixed amount a member pays for a covered health care service.

“Deductible” means the amount paid for covered health care services before the insurance plan will effect payment.

“Medicare cost sharing” means the Medicare member's responsibility for a Medicare-covered service. “Medicare cost sharing” includes coinsurance, copayments, and deductibles.

“Qualified Medicare beneficiary” or *“QMB”* means an individual who has been determined eligible for the QMB program pursuant to 441—paragraph 75.6(5)“a.” Under the QMB program, Medicaid pays the individual's Medicare Part A and B premiums, coinsurance, copayment, and deductible (except for Part D).

[ARC 0315D, IAB 5/27/26, effective 7/1/26]

441—78.58(249A) Health insurance premium payment (HIPP) provider services.

78.58(1) Reimbursement. A HIPP provider may bill the department for the HIPP-eligible member's out-of-pocket cost-sharing obligations. Reimbursement of claims is limited to in-network coinsurance, copayments, and deductibles of the HIPP-eligible member's health insurance, paid for through the HIPP program. The HIPP-eligible member may be responsible for a copayment pursuant to 441—subrule 79.1(13).

78.58(2) Definitions.

“Coinsurance” means a percentage of costs of a covered health care service that has to be paid.

“Copayment” means a fixed amount a member pays for a covered health care service.

“Cost sharing” means the member's health insurance in-network responsibility for a covered service. “Cost sharing” includes coinsurance, copayments, and deductibles.

“Deductible” means the amount paid for covered health care services before the insurance plan will effect payment.

“Eligible member” means an individual eligible for Medicaid pursuant to rule 441—75.1(249A) et seq. and who qualifies for and is participating in the department's HIPP program prescribed under rule 441—75.21(249A).

“Health insurance premium payment program” or *“HIPP program”* has the same meaning as provided in rule 441—75.21(249A).

[ARC 0315D, IAB 5/27/26, effective 7/1/26]

441—78.59(249A) Crisis response services. Payment will be made to providers (eligible pursuant to rule 441—77.54(249A)) of crisis response services, crisis stabilization community-based services, and crisis stabilization residential services delivered as set forth in 441—Chapter 24.

[ARC 0315D, IAB 5/27/26, effective 7/1/26]

441—78.60(249A) Subacute mental health services. Payment will be made to providers (eligible pursuant to rule 441—77.55(249A)) for the provision of subacute mental health care facility services that meet the standards outlined in 481—Chapter 71.

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[Filed ARC 0315D (Notice ARC 9865C, IAB 12/24/25), IAB 5/27/26, effective 7/1/26]

◇ Two or more ARCs

¹ Effective date of 78.3 and 78.31 delayed 70 days by the Administrative Rules Review Committee at its January 1, 1988 meeting.

² Effective date of 4/1/90 delayed 70 days by the Administrative Rules Review Committee at its March 12, 1990, meeting.

³ Effective date of 4/1/91 delayed until adjournment of the 1991 session of the General Assembly by the Administrative Rules Review Committee at its meeting held February 12, 1991.

⁴ Effective date of 3/1/92 delayed until adjournment of the 1992 General Assembly by the Administrative Rules Review Committee at its meeting held February 3, 1992.

⁵ At a special meeting held January 24, 2002, the Administrative Rules Review Committee voted to delay until adjournment of the 2002 Session of the General Assembly the effective date of amendments published in the February 6, 2002, Iowa Administrative Bulletin as **ARC 1365B**.

⁶ Effective date of 12/15/02 delayed 70 days by the Administrative Rules Review Committee at its December 10, 2002, meeting.

⁷ July 1, 2009, effective date of amendments to 78.27(2)“d” delayed 70 days by the Administrative Rules Review Committee at a special meeting held June 25, 2009.

⁸ May 11, 2011, effective date of 78.34(5)“d,” 78.38(5)“h,” 78.41(2)“g,” 78.43(3)“d,” and 78.52(5)“a” delayed 70 days by the Administrative Rules Review Committee at its meeting held April 11, 2011.

- ¹ July 1, 2019, effective date of **ARC 4430C** [amendments to chs 78, 79] delayed until the adjournment of the 2020 session of the General Assembly by the Administrative Rules Review Committee at its meeting held June 11, 2019; delay lifted at the meeting held September 10, 2019.
- ¹ March 18, 2020, effective date of **ARC 4899C** [amendments to chs 78, 79] delayed until the adjournment of the 2021 session of the General Assembly by the Administrative Rules Review Committee at its meeting held March 6, 2020; delay lifted at the meeting held August 11, 2020, except with respect to amendments to 78.2(6). Effective date of amendments to 78.2(6) remains delayed until the adjournment of the 2021 session of the General Assembly.

CHAPTER 79
OTHER POLICIES RELATING TO PROVIDERS OF MEDICAL AND REMEDIAL CARE
[Prior to 7/1/83, Social Services[770] Ch 79]

Chapter rescission date pursuant to Iowa Code section 17A.7: 7/1/31

441—79.1(249A) Principles governing reimbursement of providers of medical and health services. The basis of payment for services rendered by providers of services participating in the medical assistance program is either a system based on the provider's allowable costs of operation or a fee schedule. Generally, institutional types of providers such as hospitals and nursing facilities are reimbursed on a cost-related basis, and practitioners such as physicians, dentists, optometrists, and similar providers are reimbursed on the basis of a fee schedule. Providers of service must accept reimbursement based upon the department's methodology without making any additional charge to the member.

For purposes of this chapter, "managed care organization" or "MCO" means an entity that (1) is under contract with the department to provide services to Medicaid recipients and (2) meets the definition of "health maintenance organization" as defined in Iowa Code section 514B.1.

79.1(1) Types of reimbursement.

a. Prospective cost-related. Providers are reimbursed on the basis of a per diem rate calculated prospectively for each participating provider based on reasonable and proper costs of operation. The rate is determined by establishing a base year per diem rate to which an annual index is applied.

b. Retrospective cost-related. Providers are reimbursed on the basis of a per unit rate calculated retrospectively for each participating provider based on reasonable and proper costs of operation with suitable retroactive adjustments based on submission of financial and statistical reports by the provider. The retroactive adjustment represents the difference between the amount received by the provider during the year for covered services and the amount determined in accordance with an accepted method of cost apportionment (generally the Medicare principles of apportionment) to be the actual cost of service rendered medical assistance recipients.

c. Fee schedules. Fees for the various procedures involved are determined by the department with advice and consultation from the appropriate professional group. The fees are intended to reflect the amount of resources (time, training, experience) involved in each procedure. Individual adjustments will be made periodically to correct any inequity or to add new procedures or eliminate or modify others. If product cost is involved in addition to service, reimbursement is based either on a fixed fee, wholesale cost, or on actual acquisition cost of the product to the provider, or product cost is included as part of the fee schedule. Providers on fee schedules are reimbursed the lower of:

- (1) The actual charge made by the provider of service.
- (2) The maximum allowance under the fee schedule for the item of service in question.

Payment levels for fee schedule providers of service will be increased on an annual basis by an economic index reflecting overall inflation as well as inflation in office practice expenses of the particular provider category involved to the extent data is available. Annual increases will be made on July 1 of each year.

There are some variations in this methodology that are applicable to certain providers. These are set forth below in subrules 79.1(3) through 79.1(8) and 79.1(15).

Fee schedules in effect for the providers covered by fee schedules can be obtained from the department's website.

d. Reserved.

e. Retrospectively limited prospective rates. Providers are reimbursed on the basis of a rate for a unit of service calculated prospectively for each participating provider based on projected or historical costs of operation subject to the maximums listed in subrule 79.1(2) and to retrospective adjustment pursuant to subparagraph 79.1(1) "e"(3).

(1) The prospective rates for new providers that have not submitted six months of cost reports will be based on a projection of the provider's reasonable and proper costs of operation until the provider has submitted an annual cost report that includes a minimum of six months of actual costs.

(2) The prospective rates paid established providers that have submitted an annual report with a minimum of a six-month history are based on reasonable and proper costs in a base period and are adjusted annually for inflation.

(3) The prospective rates paid to both new and established providers are subject to the maximums listed in subrule 79.1(2) and to retrospective adjustment pursuant to paragraph 79.1(15) "f."

f. Contractual rate. Providers are reimbursed on a basis of costs incurred pursuant to a contract between the provider and subcontractor.

g. Retrospectively adjusted prospective rates. Critical access hospitals are reimbursed prospectively, with retrospective adjustments based on annual cost reports submitted by the hospital at the end of the hospital's fiscal year. The retroactive adjustment equals the difference between the reasonable costs of providing covered services to eligible fee-for-service Medicaid members (excluding members in managed care), determined in accordance with Medicare cost principles, and the Medicaid reimbursement received. Amounts paid that exceed reasonable costs will be recovered by the department. See paragraphs 79.1(5) "aa" and 79.1(16) "h" for more information.

h. Indian health facilities.

(1) Indian health facilities enrolled pursuant to rule 441—77.47(249A) are paid for all Medicaid-covered services rendered to American Indian or Alaskan native persons who are Medicaid-eligible at the current daily visit rates approved by the U.S. Indian Health Service (IHS) for services provided by IHS facilities to Medicaid beneficiaries, as published in the Federal Register, as amended to July 1, 2026. For services provided to American Indians or Alaskan natives, Indian health facilities may bill for one visit per patient per calendar day for medical services (at the "outpatient per visit rate (excluding Medicare)"), which will constitute payment in full for all medical services provided on that day, except as follows:

1. For services provided to American Indians and Alaskan natives, Indian health facilities may bill for multiple visits per patient per calendar day for medical services (at the "outpatient per visit rate (excluding Medicare)") only if medical services are provided for different diagnoses or if distinctly different medical services from different categories of services are provided for the same diagnoses in different units of the facility. For this purpose, the categories of medical services are vision services; dental services; mental health and addiction services; early and periodic screening, diagnosis, and treatment services for children; other outpatient services; and other inpatient services. A visit is a face-to-face contact between a patient and a health professional at or through the facility.

2. For services provided to American Indians or Alaskan natives, Indian health facilities may also bill for one visit per patient per calendar day for outpatient prescribed drugs provided by the facility (at the "outpatient per visit rate (excluding Medicare)"), which will constitute payment in full for all outpatient prescribed drugs provided on that day.

(2) Services provided to Medicaid recipients who are not American Indians or Alaskan natives will be paid at the reimbursement rate otherwise allowed by Iowa Medicaid for the services provided and will be billed separately by CPT code on the CMS-1500 Health Insurance Claim Form or through pharmacy point of sale. Claims for nonpharmacy services provided to Medicaid recipients who are not American Indians or Alaskan natives must be submitted by the individual practitioner enrolled in the Iowa Medicaid program, but may be paid to the facility if the provider agreement so stipulates.

i. Inflation factor. When the department's reimbursement methodology for any provider includes an inflation factor, this inflation factor will not exceed the amount by which the consumer price index for all urban consumers increased during the most recent calendar year.

79.1(2) *Basis of reimbursement of specific provider categories.*

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
Advanced registered nurse	Fee schedule	Fee schedule in effect 6/30/13 plus 1%

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
practitioners		
Ambulance	Fee schedule	Ground ambulance: Fee schedule in effect 6/30/14 plus 10% Air ambulance: Fee schedule in effect 7/1/21
Ambulatory surgical centers	Base rate fee schedule as determined by Medicare. See 79.1(3)	Fee schedule in effect 6/30/13 plus 1%
Applied behavior analysis	Fee schedule	Fee schedule in effect 7/1/22
Area education agencies	Fee schedule	Fee schedule in effect 6/30/00 plus 0.7%
Assertive community treatment	Fee schedule	Fee schedule in effect 7/1/19. Maximum of 5 days per week
Audiologists	Fee schedule	Fee schedule in effect 6/30/13 plus 1%
Behavioral health intervention	Fee schedule	Fee schedule in effect 7/1/22
Behavioral health services	Fee schedule	Fee schedule in effect 6/30/13 plus 1%
Birth centers	Fee schedule	Fee schedule in effect 6/30/13 plus 1%
Child care medical services	Fee schedule	Fee schedule in effect 1/1/16
Chiropractors	Fee schedule	Fee schedule in effect 6/30/13 plus 1%
Clinics	Fee schedule	Maximum physician reimbursement rate
Community-based neurobehavioral rehabilitation services	Fee schedule. See 79.1(28)	Residential: Limit in effect as of June 30 each year plus CPI-U for the preceding 12-month period ending June 30. Intermittent: \$21.11 per 15-minute unit
Community mental health centers	Retrospective cost-related. See 79.1(25)	100% of reasonable Medicaid cost as determined by Medicare cost reimbursement principles
Crisis response services	Fee schedule	Fee schedule in effect 2/1/18, not to exceed the daily per diem for crisis stabilization services
Crisis stabilization community-based services	Fee schedule	Fee schedule in effect 2/1/18, not to exceed the daily per diem for crisis stabilization services
Crisis stabilization residential services	Fee schedule	Fee schedule in effect 2/1/18
Dentists	Fee schedule	Fee schedule in effect 6/30/13 plus 1%
Drug and alcohol services	Fee schedule	Fee schedule in effect 1/1/16
Durable medical equipment, prosthetic devices and medical supply dealers	Fee schedule. See 79.1(4)	Fee schedule in effect 6/30/13 plus 1%
Emergency psychiatric services	Fee schedule	Fee schedule in effect 1/1/16
Family planning clinics	Fee schedule	Fee schedule in effect 6/30/13 plus 1%
Federally qualified health centers	Retrospective cost-related. See 441—Chapter 73	1. Prospective payment rate as required by the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA 2000) as amended to July 1, 2026, or an alternative methodology allowed thereunder, as specified in “2” below 2. 100% of reasonable cost as determined by Medicare cost reimbursement principles 3. In the case of services provided pursuant to a contract between an FQHC and an MCO, reimbursement from the MCO will be supplemented to achieve “1” or “2” above
HCBS waiver service providers, including:		Except as noted, limits apply to all waivers that cover the named provider.
1. Adult day care	For AIDS/HIV, brain injury, elderly, and health and disability waivers: Fee schedule	Effective 7/1/24, for AIDS/HIV, brain injury, elderly, and health and disability waivers: Provider’s rate in effect 6/30/24 plus 4.1%, converted to a 15-

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
		minute, half-day, full-day, or extended-day rate. If no 6/30/24 rate: Veterans Administration contract rate or \$1.64 per 15-minute unit, \$26.37 per half day, \$52.51 per full day, or \$78.73 per extended day if no Veterans Administration contract
	For intellectual disability waiver: Fee schedule for the member's acuity tier, determined pursuant to 79.1(30)	Effective 7/1/24, for intellectual disability waiver: The provider's rate in effect 6/30/24 plus 4.1%, converted to a 15-minute or half-day rate. If no 6/30/24 rate, \$2.21 per 15-minute unit or \$35.14 per half day. For daily services, the fee schedule rate published on the department's website, pursuant to 79.1(1) "c," for the member's acuity tier, determined pursuant to 79.1(30)
2. Emergency response system:		
Personal response system	Fee schedule	Effective 7/1/24, provider's rate in effect 6/30/24 plus 4.1%. If no 6/30/24 rate: Initial one-time fee: \$58.48. Ongoing monthly fee: \$45.48
Portable locator system	Fee schedule	Effective 7/1/24, provider's rate in effect 6/30/24 plus 4.1%. If no 6/30/24 rate: Initial one-time fee: \$58.48. Ongoing monthly fee: \$45.48
3. Home health aides	Fee schedule	For AIDS/HIV, elderly, and health and disability waivers effective 7/1/24: Lesser of maximum Medicare rate in effect 6/30/24 plus 4.1% or maximum Medicaid rate in effect 6/30/24 plus 4.1% For intellectual disability waiver effective 7/1/24: Lesser of maximum Medicare rate in effect 6/30/24 plus 4.1% or maximum Medicaid rate in effect 6/30/24 plus 4.1%, converted to an hourly rate
4. Homemakers	Fee schedule	Effective 7/1/24, provider's rate in effect 6/30/24 plus 4.1%, converted to a 15-minute rate. If no 6/30/24 rate: \$5.84 per 15-minute unit
5. Nursing care	Fee schedule	For AIDS/HIV, health and disability, elderly and intellectual disability waiver effective 7/1/24, provider's rate in effect 6/30/24 plus 4.1%. If no 6/30/24 rate: \$98.87 per visit
6. Respite care when provided by:		
Home health agency:		
Specialized respite	Fee schedule	Effective 8/1/25, provider's rate in effect 7/31/25 plus 0.9%, converted to a 15-minute rate. If no 7/31/25 rate: Lesser of maximum Medicare rate in effect 7/31/25 plus 0.9%, converted to a 15-minute rate, or maximum Medicaid rate in effect 7/31/25 plus 0.9%, converted to a 15-minute rate, not to exceed \$356.93 per day
Basic individual respite	Fee schedule	Effective 8/1/25, provider's rate in effect 7/31/25 plus 0.9%, converted to a 15-minute rate. If no 7/31/25 rate: Lesser of maximum Medicare rate in effect

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
		7/31/25 plus 0.9%, converted to a 15-minute rate, or maximum Medicaid rate in effect 7/31/25 plus 0.9%, converted to a 15-minute rate, not to exceed \$356.93 per day
Group respite	Fee schedule	Effective 8/1/25, provider's rate in effect 7/31/25 plus 0.9%, converted to a 15-minute rate. If no 7/31/25 rate: \$3.94 per 15-minute unit, not to exceed \$356.93 per day
Home care agency:		
Specialized respite	Fee schedule	Effective 8/1/25, provider's rate in effect 7/31/25 plus 0.9%, converted to a 15-minute rate. If no 7/31/25 rate: \$10.15 per 15-minute unit, not to exceed \$356.93 per day
Basic individual respite	Fee schedule	Effective 8/1/25, provider's rate in effect 7/31/25 plus 0.9%, converted to a 15-minute rate. If no 7/31/25 rate: \$5.41 per 15-minute unit, not to exceed \$356.93 per day
Group respite	Fee schedule	Effective 8/1/25, provider's rate in effect 7/31/25 plus 0.9%, converted to a 15-minute rate. If no 7/31/25 rate: \$3.94 per 15-minute unit, not to exceed \$356.93 per day
Nonfacility care:		
Specialized respite	Fee schedule	Effective 8/1/25, provider's rate in effect 7/31/25 plus 0.9%, converted to a 15-minute rate. If no 7/31/25 rate: \$10.15 per 15-minute unit, not to exceed \$356.73 per day
Basic individual respite	Fee schedule	Effective 8/1/25, provider's rate in effect 7/31/25 plus 0.9%, converted to a 15-minute rate. If no 7/31/22 rate: \$5.41 per 15-minute unit, not to exceed \$356.93 per day
Group respite	Fee schedule	Effective 8/1/25, provider's rate in effect 7/31/25 plus 0.9%, converted to a 15-minute rate. If no 7/31/25 rate: \$3.94 per 15-minute unit, not to exceed \$356.93 per day
Facility care:		
Hospital or nursing facility providing skilled care	Fee schedule	Effective 8/1/25, provider's rate in effect 7/31/25 plus 0.9%, converted to a 15-minute rate. If no 7/31/25 rate: \$3.94 per 15-minute unit, not to exceed \$356.93 per day
Nursing facility	Fee schedule	Effective 8/1/25, provider's rate in effect 7/31/25 plus 0.9%, converted to a 15-minute rate. If no 7/31/25 rate: \$3.94 per 15-minute unit, not to exceed \$356.93 per day
Camps	Fee schedule	Effective 8/1/25, provider's rate in effect 7/31/25 plus 0.9%, converted to a 15-minute rate. If no 7/31/25 rate: \$3.94 per 15-minute unit, not to exceed \$356.93 per day
Adult day care	Fee schedule	Effective 8/1/25, provider's rate in effect 7/31/25 plus 0.9%, converted to a 15-minute rate. If no 7/31/25 rate: \$3.94 per 15-minute unit, not to exceed \$356.93

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
Intermediate care facility for persons with an intellectual disability	Fee schedule	Effective 8/1/25, provider's rate in effect 7/31/25 plus 0.9%, converted to a 15-minute rate. If no 7/31/25 rate: \$3.94 per 15-minute unit, not to exceed \$356.93
Residential care facilities for persons with an intellectual disability	Fee schedule	Effective 8/1/25, provider's rate in effect 7/31/25 plus 0.9%, converted to a 15-minute rate. If no 7/31/25 rate: \$3.94 per 15-minute unit, not to exceed \$356.93
Foster group care	Fee schedule	Effective 8/1/25, provider's rate in effect 7/31/25 plus 0.9%, converted to a 15-minute rate. If no 7/31/25 rate: \$3.94 per 15-minute unit, not to exceed \$356.93
Child care facilities	Fee schedule	Effective 8/1/25, provider's rate in effect 7/31/25 plus 0.9%, converted to a 15-minute rate. If no 7/31/25 rate: \$3.94 per 15-minute unit, not to exceed \$356.93
7. Chore service	Fee schedule	Effective 7/1/24, provider's rate in effect 6/30/24 plus 4.1%, converted to a 15-minute rate. If no 6/30/24 rate: \$5.84 per 15-minute unit
8. Home-delivered meals	Fee schedule	\$9.11 per meal. Home-delivered liquid supplement meals are two cans per meal.
9. Home and vehicle modification	Fee schedule. See 79.1(17)	For elderly waiver: \$1,192.44 lifetime maximum For intellectual disability waiver: \$5,962.19 lifetime maximum For brain injury, health and disability, and physical disability waivers 7/1/22: \$7,154.65 per year
10. Mental health outreach providers	Fee schedule	Effective 7/1/24, provider's rate in effect 6/30/24 plus 4.1%. If no 6/30/24 rate: On-site Medicaid reimbursement rate for center or provider. Maximum of 1,440 units per year
11. Transportation	Fee schedule	Fee schedule in effect 7/1/24
12. Nutritional counseling	Fee schedule	Effective 7/1/24 for non-county contract: Provider's rate in effect 6/30/24 plus 4.1%, converted to a 15-minute rate. If no 6/30/24 rate: \$9.85 per 15-minute unit
13. Assistive devices	Fee schedule. See 79.1(17)	Effective 7/1/24: \$1,294.93 per unit
14. Senior companion	Fee schedule	Effective 7/1/24 for non-county contract: Provider's rate in effect 6/30/24 plus 4.1%, converted to a 15-minute rate. If no 6/30/24 rate: \$2.12 per 15-minute unit
15. Consumer-directed attendant care provided by:		
Agency (other than an elderly waiver assisted living program)	Fee agreed upon by member and provider	Effective 7/1/24, provider's rate in effect 6/30/24 plus 4.1%, converted to a 15-minute rate. If no 6/30/22 rate: \$6.02 per 15-minute unit, not to exceed \$139.18 per day
Assisted living program (for elderly waiver only)	Fee agreed upon by member and provider	Effective 7/1/24, provider's rate in effect 6/30/24 plus 4.1%, converted to a 15-minute rate. If no 6/30/22 rate: \$6.02 per 15-minute unit, not to exceed \$139.18 per day
16. Counseling:		

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
Individual	Fee schedule	Effective 7/1/24, provider's rate in effect 6/30/24 plus 4.15%, converted to a 15-minute rate. If no 6/30/24 rate: \$12.87 per 15-minute unit
Group	Fee schedule	First 30 minutes: effective 7/1/24, provider's rate in effect 6/30/24 plus 4.1%, converted to a 15-minute rate. If no 6/30/24 rate: \$25.74 per 15-minute unit. Rate is divided by the actual number of persons who comprise the group Each additional 15 minutes: effective 7/1/24, provider's rate in effect 6/30/24 plus 4.1% converted to a 15-minute rate. If no 6/30/24 rate: \$12.86 per 15-minute unit. Rate is divided by the actual number of persons who comprise the group
17. Case management	Fee schedule	For brain injury and elderly waivers: Fee schedule in effect 7/1/24, provider's rate in effect 6/30/24 plus 4.1%
18. Supported community living	For brain injury waiver: Retrospectively limited prospective rates. See 79.1(15) For intellectual disability waiver: Fee schedule for the member's acuity tier, determined pursuant to 79.1(30). Retrospectively limited prospective rate for SCL 15-minute unit. See 79.1(15)	For brain injury waiver effective 7/1/22: \$11.59 per 15-minute unit; \$565.02 daily For intellectual disability waiver effective 7/1/24: \$11.59 per 15-minute unit. For daily service, the fee schedule rate published on the department's website, pursuant to 79.1(1) "c," for the member's acuity tier, determined pursuant to 79.1(30)
19. Supported employment:		
Individual supported employment	Fee schedule	Fee schedule in effect 7/1/24. Total monthly cost for all supported employment services not to exceed \$3,692.34 per month
Long-term job coaching	Fee schedule	Fee schedule in effect 7/1/24. Total monthly cost for all supported employment services not to exceed \$3,692.34 per month
Small-group supported employment (2 to 8 individuals)	Fee schedule	Fee schedule in effect 7/1/24. Maximum 160 units per week. Total monthly cost for all supported employment services not to exceed \$3,692.34 per month
20. Specialized medical equipment	Fee schedule. See 79.1(17)	Effective 7/1/24, \$7,154.64 per year
21. Behavioral programming	Fee schedule	Effective 7/1/24, \$12.87 per 15 minutes
22. Family counseling and training	Fee schedule	Effective 7/1/24, \$12.86 per 15-minute unit
23. Prevocational services, including career exploration	Fee schedule	Fee schedule in effect 7/1/24
24. Interim medical monitoring and treatment:		
Home health agency (provided by home health aide)	Fee schedule	Effective 7/1/24: Lesser of maximum Medicare rate in effect 6/30/24 plus 4.1%, converted to a 15-minute rate, or maximum Medicaid rate in effect 6/30/24 plus 4.1%, converted to a 15-minute rate
Home health agency (provided by nurse)	Fee schedule	Effective 7/1/24: Lesser of maximum Medicare rate in effect 6/30/24 plus 4.1%, converted to a 15-minute rate, or maximum Medicaid rate in effect

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
Child development home or center	Fee schedule	6/30/24 plus 4.1%, converted to a 15-minute rate Effective 7/1/22, provider's rate in effect 6/30/22 plus 4.25%, converted to a 15-minute rate. If no 6/30/22 rate: \$3.76 per 15-minute unit
Supported community living provider	Retrospectively limited prospective rate. See 79.1(15)	Effective 7/1/24, provider's rate in effect 6/30/24 plus 4.1%, converted to a 15-minute rate. If no 6/30/24 rate: \$10.43 per 15-minute unit, not to exceed the maximum ICF/ID rate per day plus 11.727%
25. Residential-based supported community living	Fee schedule for the member's acuity tier, determined pursuant to 79.1(30)	Effective 7/1/24: The fee schedule rate published on the department's website, pursuant to 79.1(1) "c," for the member's acuity tier, determined pursuant to 79.1(30)
26. Day habilitation	Fee schedule for the member's acuity tier, determined pursuant to 79.1(30)	Effective 8/1/25: Provider's rate in effect 7/31/25 plus 0.9%, converted to a 15-minute rate. If no 7/31/25 rate: \$3.97 per 15-minute unit. For daily service, the fee schedule rate published on the department's website, pursuant to 79.1(1) "c," for the member's acuity tier, determined pursuant to 79.1(30)
27. Environmental modifications and adaptive devices	Fee schedule. See 79.1(17)	Effective 7/1/24, \$7,154.64 per year
28. Family and community support services	Retrospectively limited prospective rates. See 79.1(15)	Effective 7/1/24, \$10.43 per 15-minute unit
29. In-home family therapy	Fee schedule	Effective 7/1/24, provider's rate in effect 6/30/24 plus 4.1%, converted to a 15-minute rate. If no 6/30/24 rate: \$27.92 per 15-minute unit
30. Financial management services	Fee schedule	Effective 7/1/24, \$77.51 per enrolled member per month
31. Independent support broker	Rate negotiated by member	Effective 7/1/24, \$18.06 per hour
32. Self-directed personal care	Rate negotiated by member	Determined by member's individual budget. When an individual who serves as a member's legal representative provides services to the member as allowed by the payment rate must be based on 441—subparagraph 78.34(13) "g"(2)
33. Self-directed community supports and employment	Rate negotiated by member	Determined by member's individual budget. When an individual who serves as a member's legal representative provides services to the member as allowed by 79.9(7) "b," the payment rate must be based on 441—subparagraph 78.34(13) "g"(2)
34. Individual-directed goods and services	Rate negotiated by member	Determined by member's individual budget. When an individual who serves as a member's legal representative provides services to the member as allowed by 79.9(7) "b," the payment rate must be based on 441—subparagraph 78.34(13) "g"(2)
35. Assisted living on-call service providers (elderly waiver only)	Fee agreed upon by member and provider	\$29.31 per day
Hearing aid dispensers	Fee schedule plus product acquisition cost	Fee schedule in effect 6/30/13 plus 1%
Home- and community-based		

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
habilitation services:		
1. Case management	Fee schedule	Effective 7/1/22: Fee schedule in effect 6/30/22 plus 4.25%
2. Home-based habilitation	Fee schedule	Fee schedule in effect 7/1/24
3. Day habilitation	Fee schedule	Effective 7/1/24: \$3.75 per 15-minute unit or \$72.90 per day
4. Prevocational habilitation Career exploration	Fee schedule	Fee schedule in effect 7/1/24
5. Supported employment:		
Individual supported employment	Fee schedule	Fee schedule in effect 7/1/24. Total monthly cost for all supported employment services not to exceed \$3,692.34 per month
Long-term job coaching	Fee schedule	Fee schedule in effect 7/1/24. Total monthly cost for all supported employment services not to exceed \$3,692.34 per month
Small-group supported employment (2 to 8 individuals)	Fee schedule	Fee schedule in effect 7/1/24. Maximum 160 units per week. Total monthly cost for all supported employment services not to exceed \$3,692.34 per month
Individual placement and support supported employment	Fee schedule	Fee schedule in effect 7/1/24. Total monthly cost for all supported employment services not to exceed \$3,692.34 per month
Home health agencies		
1. Skilled nursing, physical therapy, occupational therapy, speech therapy, home health aide, and medical social services; home health care for maternity patients and children	Fee schedule. See 79.1(26). For members living in a nursing facility, see 441—paragraph 81.5(11)“q”	Effective 7/1/22: The Medicaid LUPA fee schedule rate published on the department’s website
2. Private-duty nursing and personal cares for members aged 20 or under	Retrospective cost-related. See 79.1(27)	Effective 7/1/13: Actual and allowable cost not to exceed a maximum of 133% of statewide average
3. Administration of vaccines	Physician fee schedule	Physician fee schedule rate
Hospices	Fee schedule as determined by Medicare	Medicare cap. (See 79.1(14)“d”)
Hospitals (Critical access)	Retrospectively adjusted prospective rates. See 79.1(1)“g” and 79.1(5)	The reasonable cost of covered services provided to medical assistance recipients or the upper limits for other hospitals, whichever is greater
Hospitals (Inpatient)	Prospective reimbursement. See 79.1(5)	Reimbursement rate in effect 10/1/2021
Hospitals (Outpatient)	Prospective reimbursement or hospital outpatient fee schedule. See 79.1(16)“c”	Ambulatory payment classification rate or hospital outpatient fee schedule rate in effect 1/1/2021
Independent laboratories	Fee schedule. See 79.1(6)	Medicare fee schedule less 5%. See 79.1(6)
Indian health facilities	1. Daily visit rate approved by the U.S. Indian Health Service (IHS) for services provided to American Indian and Alaskan native members. See 79.1(1)“h” 2. Fee schedule for service provided for all other Medicaid members.	1. IHS-approved rate published in the Federal Register as outpatient per visit rate (excluding Medicare) 2. Fee schedule
Infant and toddler program providers	Fee schedule	Fee schedule
Intermediate care facilities for persons with an intellectual disability	Prospective reimbursement. See 441—82.4(249A)	Eightieth percentile of facility costs as calculated from annual cost reports
Lead inspection agency	Fee schedule	Fee schedule in effect 6/30/13 plus 1%

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
Local education agency services providers	Fee schedule	Fee schedule
Maternal health centers	Reasonable cost per procedure on a prospective basis as determined by the department based on financial and statistical data submitted annually by the provider group	Fee schedule in effect 6/30/13 plus 1%
Nursing facilities:		
1. Nursing facility care	Prospective reimbursement. See 441—subrule 81.8(1) and 441—81.5(249A). The percentage of the median used to calculate the direct care excess payment allowance ceiling under 441—numbered paragraphs 81.5(16)“d”(1)“1” and (2)“1” is 95% of the patient-day-weighted median. The percentage of the difference used to calculate the direct care excess payment allowance is 0%. The percentage of the median used to calculate the direct care excess payment allowance limit is 10% of the patient-day-weighted median. The percentage of the median used to calculate the non-direct care excess payment allowance ceiling under 441—numbered paragraphs 81.5(16)“d”(1)“2” and (2)“2” is 96% of the patient-day-weighted median. The percentage of the difference used to calculate the non-direct care excess payment allowance limit is 0%. The percentage of the median used to calculate the non-direct care excess payment allowance limit is 8% of the patient-day-weighted median.	See 441—subrules 81.5(4) and 81.5(14) and paragraph 81.5(16)“f.” The direct care rate component limit under 441—subparagraphs 81.5(16)“f”(1) and “f”(2) is 120% of the patient-day-weighted median. The non-direct care rate component limit under 441—subparagraphs 81.5(16)“f”(1) and “f”(2) is 110% of the patient-day-weighted median
2. Hospital-based, Medicare-certified nursing care	Prospective reimbursement. See 441—subrule 81.8(1) and 441—81.5(249A). The percentage of the median used to calculate the direct care excess payment allowance ceiling under 441—numbered paragraph 81.5(16)“d”(3)“1” is 95% of the patient-day-weighted median. The percentage of the difference used to calculate the direct care excess payment allowance is 0%. The percentage of the median used to calculate the direct care excess payment allowance limit is 10% of the patient-day-weighted median. The percentage of the median used to calculate the non-direct care excess payment allowance ceiling under 441—numbered paragraph 81.5(16)“d”(3)“2” is 96% of the patient-day-weighted median. The percentage of the difference used to calculate the non-direct care excess payment allowance limit is 0%. The percentage of the median used to calculate the non-direct care excess payment allowance limit is 8% of the patient-day-weighted median	See 441—subrules 81.5(4) and 81.5(14) and paragraph 81.5(16)“f.” The direct care rate component limit under 441—subparagraph 81.5(16)“f”(3) is 120% of the patient-day-weighted median. The non-direct care rate component limit under 441—subparagraph 81.5(16)“f”(3) is 110% of the patient-day-weighted median

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
Occupational therapists	Fee schedule. For members residing in a nursing facility, see 441—paragraph 81.5(11) “q”	Fee schedule in effect 6/30/13 plus 1%
Opticians	Fee schedule. Fixed fee for lenses and frames; other optical materials at product acquisition cost	Fee schedule in effect 6/30/13 plus 1%
Optometrists	Fee schedule. Fixed fee for lenses and frames; other optical materials at product acquisition cost	Fee schedule in effect 6/30/13 plus 1%
Orthopedic shoe dealers	Fee schedule	Fee schedule in effect 6/30/13 plus 1%
Pharmaceutical case management	Fee schedule. See 79.1(18)	Refer to 79.1(18)
Pharmacist vaccine administration	Physician fee schedule for immunization administration	Fee schedule in effect 6/30/13 plus 1%
Physical therapists	Fee schedule. For members residing in a nursing facility, see 441—paragraph 81.5(11) “q”	Fee schedule in effect 6/30/13 plus 1%
Physicians (doctors of medicine or osteopathy)	Fee schedule. See 79.1(7) “a”	Fee schedule in effect 6/30/13 plus 1%
Anesthesia services	Fee schedule. See 79.1(7) “d”	Fee schedule in effect 7/1/17. See 79.1(7) “d”
Physician-administered drugs	Fee schedule	Fee schedule in effect 6/30/13 plus 1%
Qualified primary care services	See 79.1(7) “c”	Rate provided by 79.1(7) “c”
Podiatrists	Fee schedule	Fee schedule in effect 6/30/13 plus 1%
Prescribed drugs	See 79.1(8)	Amount pursuant to 79.1(8)
Psychiatric medical institutions for children:		
1. Inpatient in non-state-owned facilities	Fee schedule	Effective 7/1/21: Non-state-owned facilities provider-specific fee schedule in effect
2. Inpatient in state-owned facilities	Retrospective cost-related	Effective 8/1/11: 100% of actual and allowable cost
3. Outpatient day treatment	Fee schedule	Fee schedule in effect 6/30/13 plus 1%
Psychiatric services	Fee schedule	Fee schedule in effect 1/1/16
Psychologists	Fee schedule	Fee schedule in effect 6/30/13 plus 1%
Public health agencies	Fee schedule	Fee schedule rate in effect 6/30/13 plus 1%
Rehabilitation agencies	Fee schedule. For members residing in a nursing facility, see 441—paragraph 81.5(11) “q”	Medicaid fee schedule in effect 6/30/13 plus 1%; refer to 79.1(21)
Rural health clinics	Retrospective cost-related. See 441—Chapter 73	1. Prospective payment rate as required by the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA 2000) as amended to July 1, 2026, or an alternative methodology allowed thereunder, as specified in “2” below 2. 100% of reasonable cost as determined by Medicare cost reimbursement principles 3. In the case of services provided pursuant to a contract between an RHC and an MCO, reimbursement from the MCO will be supplemented to achieve “1” or “2” above
Screening centers	Fee schedule	Fee schedule in effect 6/30/13 plus 1%
Speech-language pathologists	Fee schedule	Fee schedule in effect 6/30/13 plus 1%
Subacute mental health facility	Fee schedule	Fee schedule in effect 2/1/18
Targeted case management providers	Fee schedule	Fee schedule in effect 7/1/18

79.1(3) Ambulatory surgical centers.

a. Payment is made for facility services on a fee schedule determined by the department and published on the department's website. These fees are grouped into nine categories corresponding to the difficulty or complexity of the surgical procedure involved.

b. Services of the physician or the dentist are reimbursed on the basis of a fee schedule (see paragraph 79.1(1) "c"). This payment is made directly to the physician or dentist.

79.1(4) Durable medical equipment, prosthetic devices, medical supply dealers. Fees for durable medical appliances, prosthetic devices and medical supplies are developed from several pricing sources and are based on pricing appropriate to the date of service; prices are developed using prior calendar year price information. The average wholesale price from all available sources is averaged to determine the fee for each item. Payment for used equipment will be no more than 80 percent of the purchase allowance. For supplies, equipment, and servicing of standard wheelchairs, standard hospital beds, enteral nutrients, and enteral and parenteral supplies and equipment, the fee for payment will be the lowest price for which the devices are widely and consistently available in a locality. Reimbursement over an established Medicaid fee schedule amount may be allowed pursuant to the criteria at 441—paragraph 78.10(5) "n."

79.1(5) Reimbursement for hospitals.

a. *Definitions.*

"Adolescent" means a Medicaid patient 17 years or younger.

"Adult" means a Medicaid patient 18 years or older.

"Average daily rate" means the hospital's final payment rate multiplied by the DRG weight and divided by the statewide average length of stay for a DRG.

"Base year cost report" means the hospital's cost report with fiscal year end on or after January 1, 2019, and before January 1, 2020, except as noted in paragraph 79.1(5) "x." Cost reports will be reviewed using Medicare's cost reporting and cost reimbursement principles for those cost reporting periods.

"Blended base amount" means the case-mix-adjusted, hospital-specific operating cost per discharge associated with treating Medicaid patients, plus the statewide average case-mix-adjusted operating cost per Medicaid discharge, divided by two. This base amount is the value to which payments for capital costs are added to form a final payment rate. The costs of hospitals receiving reimbursement as critical access hospitals during any of the period included in the base year cost report will not be used in determining the statewide average case-mix-adjusted operating cost per Medicaid discharge.

For purposes of calculating the disproportionate share rate only, a separate blended base amount will be determined for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children. This separate amount will be determined using only the case-mix-adjusted operating cost per discharge associated with treating Medicaid patients in the distinct area or areas of the hospital where services are provided predominantly to children under 18 years of age.

"Blended capital costs" means case-mix-adjusted hospital-specific capital costs, plus statewide average capital costs, divided by two. The costs of hospitals receiving reimbursement as critical access hospitals during any of the period of time included in the base year cost report will not be used in determining the statewide average capital costs.

For purposes of calculating the disproportionate share rate only, separate blended capital costs will be determined for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children, using only the capital costs related to the distinct area or areas of the hospital where services are provided predominantly to children under 18 years of age.

"Capital costs" means an add-on to the blended base amount, which will compensate for Medicaid's portion of capital costs. Capital costs for buildings, fixtures and movable equipment are defined in the hospital's base year cost report, are case-mix adjusted, are adjusted to reflect 80

percent of allowable costs, and are adjusted to be no greater than one standard deviation off the mean Medicaid blended capital rate.

For purposes of calculating the disproportionate share rate only, separate capital costs shall be determined for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children, using only the base year cost report information related to the distinct area or areas of the hospital where services are provided predominantly to children under 18 years of age.

"Case-mix adjusted" means the division of the hospital-specific base amount or other applicable components of the final payment rate by the hospital-specific case-mix index. For purposes of calculating the disproportionate share rate only, a separate case-mix adjustment shall be determined for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children, using the base amount or other applicable component for the distinct area or areas of the hospital where services are provided predominantly to children under 18 years of age.

"Case-mix index" means an arithmetical index measuring the relative average costliness of cases treated in a hospital compared to the statewide average. For purposes of calculating the disproportionate share rate only, a separate case-mix index will be determined for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children, using the average costliness of cases treated in the distinct area or areas of the hospital where services are provided predominantly to children under 18 years of age.

"Children's hospitals" means hospitals with inpatients predominantly under 18 years of age. For purposes of qualifying for disproportionate share payments from the graduate medical education and disproportionate share fund, a children's hospital is defined as a duly licensed hospital that:

1. Either provides services predominantly to children under 18 years of age or includes a distinct area or areas that provide services predominantly to children under 18 years of age, and
2. Is a voting member of the National Association of Children's Hospitals and Related Institutions for dates of service prior to October 1, 2014, or a member of the National Association of Children's Hospitals and Related Institutions for dates of service on or after October 1, 2014.

"Cost outlier" means cases that have an extraordinarily high cost as established in paragraph 79.1(5)"f," so as to be eligible for additional payments above and beyond the initial DRG payment.

"Critical access hospital" or *"CAH"* means a hospital licensed as a critical access hospital by the department of inspections, appeals, and licensing pursuant to rule 481—51.27(135B).

"Diagnosis-related group" or *"DRG"* means a group of similar diagnoses combined based on patient age, procedure coding, comorbidity, and complications.

"Direct medical education costs" means costs directly associated with the medical education of interns and residents or other medical education programs, such as a nursing education program or allied health programs, conducted in an inpatient setting, that qualify for payment as medical education costs under the Medicare program. The amount of direct medical education costs is determined from the hospital base year cost reports multiplied by a factor to maintain expenditures within the amount appropriated to the department for this purpose and then case-mix adjusted in determining the direct medical education rate. Payment for direct medical education costs will be made from the graduate medical education and disproportionate share fund and will not be added to the reimbursement for claims.

For purposes of calculating the disproportionate share rate only, separate direct medical education costs will be determined for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children, using only costs associated with the distinct area or areas in the hospital where services are provided predominantly to children under 18 years of age.

"Direct medical education rate" means a rate calculated for a hospital reporting medical education costs on the Medicare cost report (CMS 2552). The rate is calculated using the following formula: Direct medical education costs are multiplied by a factor to maintain expenditures within the amount

appropriated to the department for this purpose. The result is divided by the hospital's case-mix index, then is further divided by net discharges.

For purposes of calculating the disproportionate share rate only, a separate direct medical education rate will be determined for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children, using the direct medical education costs, case-mix index, and net discharges of the distinct area or areas in the hospital where services are provided predominantly to children under 18 years of age.

"Disproportionate share payment" means a payment that will compensate for treatment of a disproportionate share of poor patients. The disproportionate share payment will be made directly from the graduate medical education and disproportionate share fund and will not be added to the reimbursement for claims.

"Disproportionate share percentage" means either (1) the product of 2½ percent multiplied by the number of standard deviations by which the hospital's own Medicaid inpatient utilization rate exceeds the statewide mean Medicaid inpatient utilization rate for all hospitals, or (2) 2½ percent. (See subparagraph 79.1(5)"y"(7) for more information.)

A separate disproportionate share percentage will be determined for any hospital that qualifies for a disproportionate share payment only as a children's hospital, using the Medicaid inpatient utilization rate for children under 18 years of age at the time of admission in all distinct areas of the hospital where services are provided predominantly to children under 18 years of age.

"Disproportionate share rate" means the sum of the blended base amount, blended capital costs, direct medical education rate, and indirect medical education rate multiplied by the disproportionate share percentage.

"DRG weight" means a number that reflects relative resource consumption as measured by the relative charges by hospitals for cases associated with each DRG. That is, the Iowa-specific DRG weight reflects the relative charge for treating cases classified in a particular DRG compared to the average charge for treating all Medicaid cases in all DRGs in Iowa hospitals.

"Final payment rate" means the aggregate sum of the two components (the blended base amount and capital costs) that, when added together, form the final dollar value used to calculate each provider's reimbursement amount when multiplied by the DRG weight. These dollar values are displayed on the rate table listing.

"Full DRG transfer" means that a case, coded as a transfer to another hospital, will be considered to be a normal claim for recalibration or rebasing purposes if payment is equal to or greater than the full DRG payment.

"GME/DSH fund apportionment claim set" means the hospital's applicable Medicaid base year cost report period. The claim set is updated in July of every third year and is modeled using recalibrated rates pursuant to paragraph 79.1(5)"k."

"GME/DSH fund implementation year" means 2022.

"Graduate medical education and disproportionate share fund" or *"GME/DSH fund"* means a reimbursement fund developed as an adjunct reimbursement methodology to directly reimburse qualifying hospitals for the direct and indirect costs associated with the operation of graduate medical education programs and the costs associated with the treatment of a disproportionate share of poor, indigent, nonreimbursed or nominally reimbursed patients for inpatient services.

"Indirect medical education rate" means a rate calculated as follows: The statewide average case-mix adjusted operating cost per Medicaid discharge, divided by two, is added to the statewide average capital costs, divided by two. The resulting sum is then multiplied by the ratio of the number of full-time equivalent interns and residents serving in a Medicare-approved hospital teaching program divided by the number of beds included in hospital departments served by the interns' and residents' program and is further multiplied by 1.159.

For purposes of calculating the disproportionate share rate only, a separate indirect medical education rate will be determined for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children, using the number of

full-time equivalent interns and residents and the number of beds in the distinct area or areas in the hospital where services are provided predominantly to children under 18 years of age.

“Inlier” means those cases where the length of stay or cost of treatment falls within the actual calculated length of stay criteria or the cost of treating a patient is within the cost boundaries of a DRG payment.

“Long stay outlier” means cases that have an associated length of stay that is greater than the calculated length of stay parameters as defined within the length of stay calculations for that DRG. Payment is as established in paragraph 79.1(5) *“f.”*

“Low-income utilization rate” means the ratio of gross billings for all Medicaid, bad debt, and charity care patients, including billings for Medicaid enrollees of managed care organizations and primary care case management organizations, to total billings for all patients. Gross billings do not include cash subsidies received by the hospital for inpatient hospital services except as provided from state or local governments.

A separate low-income utilization rate will be determined for any hospital qualifying or seeking to qualify for a disproportionate share payment as a children’s hospital, using only billings for patients under 18 years of age at the time of admission in the distinct area or areas in the hospital where services are provided predominantly to children under 18 years of age.

“Medicaid claim set” means the hospital’s applicable Medicaid claims for the period of January 1, 2018, through December 31, 2019, and paid through March 31, 2020.

“Medicaid inpatient utilization rate” means the number of total Medicaid days, including days for Medicaid enrollees of managed care organizations and primary care case management organizations, both in-state and out-of-state, and Iowa state indigent patient days divided by the number of total inpatient days for both in-state and out-of-state recipients. Children’s hospitals, including hospitals qualifying for disproportionate share as a children’s hospital, receive twice the percentage of inpatient hospital days attributable to Medicaid patients.

A separate Medicaid inpatient utilization rate will be determined for any hospital qualifying or seeking to qualify for a disproportionate share payment as a children’s hospital, using only Medicaid days, Iowa state indigent patient days, and total inpatient days attributable to patients under 18 years of age at the time of admission in all distinct areas of the hospital where services are provided predominantly to children under 18 years of age.

“Neonatal intensive care unit” means a designated level II or level III neonatal unit.

“Net discharges” means total discharges minus transfers and short stay outliers.

“Rate table listing” means a schedule of rate payments for each provider. The rate table listing is defined as the output that shows the final payment rate by a hospital before being multiplied by the appropriate DRG weight.

“Rebasing” means the redetermination of the blended base amount or other applicable components of the final payment rate from more recent Medicaid cost report data.

“Rebasing implementation year” means 2021 and every three years thereafter.

“Recalibration” means the adjustment of all DRG weights to reflect changes in relative resource consumption.

“Short stay day outlier” means cases that have an associated length of stay that is less than the calculated length of stay parameters as defined within the length of stay calculations. Payment rates are established in paragraph 79.1(5) *“f.”*

b. Determination of final payment rate amount. The hospital DRG final payment amount reflects the sum of inflation adjustments to the blended base amount plus an add-on for capital costs. This blended base amount plus the add-on is multiplied by the set of Iowa-specific DRG weights to establish a rate schedule for each hospital. Federal DRG definitions are adopted except as provided below:

(1) Substance abuse units certified pursuant to paragraph 79.1(5) *“r.”* Three sets of DRG weights are developed for DRGs concerning rehabilitation of substance abuse patients. The first set of weights is developed from charges associated with treating adults in certified substance abuse units. The

second set of weights reflects charges associated with treating adolescents in mixed-age certified substance abuse units. The third set of weights reflects charges associated with treating adolescents in designated adolescent-only certified substance abuse units.

Hospitals with these units are reimbursed using the weight that reflects the age of each patient. Out-of-state hospitals may not receive reimbursement for the rehabilitation portion of substance abuse treatment.

(2) Neonatal intensive care units certified pursuant to paragraph 79.1(5)“r.” Three sets of weights are developed for DRGs concerning treatment of neonates. One set of weights is developed from charges associated with treating neonates in a designated level III neonatal intensive care unit for some portion of their hospitalization. The second set of weights is developed from charges associated with treating neonates in a designated level II neonatal intensive care unit for some portion of their hospitalization. The third set of weights reflects charges associated with neonates not treated in a designated level II or level III setting. Hospitals are reimbursed using the weight that reflects the setting for neonate treatment.

c. Calculation of Iowa-specific weights and case-mix index. From the Medicaid claim set, the recalibration for rates effective October 1, 2021, will use all normal inlier claims, discard short stay outliers, discard transfers where the final payment is less than the full DRG payment, include transfers where the full payment is greater than or equal to the full DRG payment, and use only the estimated charge for the inlier portion of long stay outliers and cost outliers for weighting calculations. These are referred to as trimmed claims.

(1) Iowa-specific weights are calculated with Medicaid cost data less medical education from the Medicaid claim set using trimmed claims. Medicaid cost data for hospitals receiving reimbursement as critical access hospitals during any of the period included in the base year cost report will not be used in calculating Iowa-specific weights. One weight is determined for each DRG with noted exceptions pursuant to paragraph 79.1(5)“b.” Weights are determined through the following calculations:

1. Determine the statewide geometric mean cost for all cases classified in each DRG.
2. Compute the statewide aggregate geometric mean cost for each DRG by multiplying the statewide geometric mean cost for each DRG by the total number of cases classified in that DRG.
3. Sum the statewide aggregate geometric mean costs for all DRGs and divide by the total number of cases for all DRGs to determine the weighted average geometric mean cost for all DRGs.
4. Divide the statewide geometric mean cost for each DRG by the weighted average geometric mean cost for all DRGs to derive the Iowa-specific weight for each DRG.
5. Normalize the weights so that the average case has a weight of one.

(2) The hospital-specific case-mix index is computed by taking each hospital’s trimmed claims that match the hospital’s base year cost reporting period, summing the assigned DRG weights associated with those claims and dividing by the total number of Medicaid claims associated with that specific hospital for that period. Case-mix indices are not computed for hospitals receiving reimbursement as critical access hospitals.

(3) For purposes of calculating the disproportionate share rate only, a separate hospital-specific case-mix index will be computed for any hospital that qualifies for a disproportionate share payment only as a children’s hospital. The computation will use only claims and associated DRG weights for services provided to patients under 18 years of age at the time of admission in all distinct areas of the hospital where services are provided predominantly to children under 18 years of age.

d. Calculation of blended base amount. The DRG blended base amount reflects a 50/50 blend of statewide and hospital-specific base amounts.

(1) Calculation of statewide average case-mix-adjusted cost per discharge. The statewide average cost per discharge is calculated by subtracting from the statewide total Iowa Medicaid inpatient expenditures multiplied by a factor to maintain expenditures within the amount appropriated to the department for this purpose:

1. The total calculated dollar expenditures based on hospitals' base year cost reports for capital costs and medical education costs, multiplied by a factor to maintain expenditures within the amount appropriated to the department for this purpose, and

2. The actual payments made for additional transfers, outliers, physical rehabilitation services, psychiatric services, and indirect medical education.

Cost report data for hospitals receiving reimbursement as critical access hospitals during any of the period of time included in the base year cost report is not used in calculating the statewide average cost per discharge. The remaining amount (which has been case-mix adjusted) is divided by the statewide total number of Iowa Medicaid discharges reported in the Medicaid management information system (MMIS) less an actual number of nonfull DRG transfers and short stay outliers.

- (2) Calculation of hospital-specific case-mix-adjusted average cost per discharge. The hospital-specific case-mix-adjusted average cost per discharge is calculated by subtracting from the lesser of total Iowa Medicaid costs or covered reasonable charges, as determined by the hospital's base year cost report or MMIS claims system, the actual dollar expenditures for capital costs, and direct medical education costs multiplied by an amount to maintain expenditures within the amount appropriated to the department for this purpose, and then subtracting payments made for nonfull DRG transfers, outliers, physical rehabilitation services, and psychiatric services, if applicable. The remaining amount is case-mix adjusted, multiplied by inflation factors, and divided by the total number of Iowa Medicaid discharges from the MMIS claims system for that hospital during the applicable base year, less the nonfull DRG transfers and short stay outliers.

For purposes of calculating the disproportionate share rate only, a separate hospital-specific case-mix-adjusted average cost per discharge will be calculated for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children, using the costs, charges, expenditures, payments, discharges, transfers, and outliers attributable to the distinct area or areas in the hospital where services are provided predominantly to children under 18 years of age.

- (3) Calculation of the blended statewide and hospital-specific base amount. The hospital-specific case-mix adjusted average cost per discharge is added to the case-mix adjusted statewide average cost per discharge and divided by two to arrive at a 50/50 blended base amount.

e. Add-ons to the base amount.

- (1) One payment for capital costs is added on to the blended base amount.

Capital costs are included in the rate table listing and added to the blended base amount before the final payment rate schedule is set. This add-on reflects a 50/50 blend of the statewide average case-mix-adjusted capital cost per discharge and the case-mix-adjusted hospital-specific base year capital cost per discharge attributed to Iowa Medicaid patients.

Allowable capital costs are determined by multiplying the capital amount from the base year cost report by 80 percent and then multiplied by a factor to maintain expenditures within the amount appropriated to the department for this purpose. Cost report data for hospitals receiving reimbursement as critical access hospitals during any of the period of time included in the base year cost report is not used in calculating the statewide average case-mix-adjusted capital cost per discharge.

The 50/50 blend is calculated by adding the case-mix-adjusted hospital-specific per discharge capital cost to the statewide average case-mix-adjusted per discharge capital costs and dividing by two. Hospitals whose blended capital add-on exceeds one standard deviation off the mean Medicaid blended capital rate will be subject to a reduction in their capital add-on to equal the first standard deviation.

For purposes of calculating the disproportionate share rate only, a separate add-on to the base amount for capital costs will be calculated for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children, using the case-mix-adjusted hospital-specific base year capital cost per discharge attributed to Iowa Medicaid

patients in the distinct area or areas in the hospital where services are provided predominantly to children under 18 years of age.

(2) Reserved.

f. Outlier payment policy. Additional payment is made for approved cases meeting or exceeding Medicaid criteria for day and cost outliers for each DRG. One hundred percent of outlier costs will be paid to facilities at the time of claim reimbursement. Iowa Medicaid will perform retrospective outlier reviews.

(1) Long stay outliers. Long stay outliers are incurred when a patient's stay exceeds the upper day limit threshold. This threshold is defined as the lesser of the arithmetically calculated average length of stay plus 23 days of care or two standard deviations above the average statewide length of stay for a given DRG, calculated geometrically. Reimbursement for long stay outliers is calculated at 60 percent of the average daily rate for the given DRG for each approved day of stay beyond the upper day limit. Payment for long stay outliers will be paid at 100 percent of the calculated amount and made at the time the claim is originally paid.

(2) Short stay outliers. Short stay outliers are incurred when a patient's length of stay is greater than two standard deviations from the geometric mean below the average statewide length of stay for a given DRG, rounded to the next highest whole number of days. Payment for short stay outliers will be 200 percent of the average daily rate for each day the patient qualifies up to the full DRG payment. Short stay outlier claims will be subject to Iowa Medicaid review and payment denied for inappropriate admissions.

(3) Cost outliers. Cases qualify as cost outliers when costs of service in a given case, not including any add-on amounts for direct or indirect medical education or disproportionate share costs exceed the cost threshold. This cost threshold is determined to be the greater of two times the statewide average DRG payment for that case or the hospital's individual DRG payment for that case plus \$75,000. Costs are calculated using hospital-specific cost-to-charge ratios determined in the base year cost reports. Additional payment for cost outliers is 80 percent of the excess between the hospital's cost for the discharge and the cost threshold established to define cost outliers. Payment of cost outlier amounts will be paid at 100 percent of the calculated amount and made at the time the claim is paid.

Those hospitals that are notified of any outlier review initiated by Iowa Medicaid must submit all requested supporting data to Iowa Medicaid within 60 days of the receipt of outlier review notification, or outlier payment will be forfeited and recouped. In addition, any hospital may request a review for outlier payment by submitting documentation to Iowa Medicaid within 365 days of receipt of the outlier payment. If requests are not filed within 365 days, the provider loses the right to appeal or contest that payment.

(4) Day and cost outliers. Cases qualifying as both day and cost outliers are given additional payment as cost outliers only.

g. Billing for patient transfers and readmissions.

(1) Transfers between hospitals. When a Medicaid patient is transferred, the initial hospital or unit is paid 100 percent of the average daily rate of the transferring hospital's payment for each day the patient remained in that hospital or unit, up to 100 percent of the entire DRG payment. The hospital or unit that received the transferred patient receives the entire DRG payment.

(2) Substance abuse units. When a patient is discharged to or from an acute care hospital and is admitted to or from a substance abuse unit certified pursuant to paragraph 79.1(5)"r," both the discharging and admitting hospitals will receive 100 percent of the DRG payment.

(3) Physical rehabilitation hospitals or units. When a patient requiring physical rehabilitation is discharged from an acute care hospital and admitted to a rehabilitation hospital or unit certified pursuant to paragraph 79.1(5)"r," and the admission is medically appropriate, then payment for time spent in the unit is through a per diem. The discharging hospital will receive 100 percent of the DRG payment. When a patient is discharged from a certified physical rehabilitation hospital or unit

and admitted to an acute care hospital, the acute care hospital will receive 100 percent of the DRG payment.

When a patient requiring physical rehabilitation is discharged from a facility other than an acute care hospital and admitted to a rehabilitation hospital or unit certified pursuant to paragraph 79.1(5)“r,” and the admission is medically appropriate, then payment for time spent in the unit is based on a per diem. The other facility will receive payment in accordance with rules governing that facility. When a patient is discharged from a certified physical rehabilitation hospital or unit and admitted to a facility other than an acute care hospital, the other facility will receive payment in accordance with rules governing that facility.

(4) Psychiatric units.

When a patient requiring psychiatric care is discharged from an acute care hospital and admitted to a psychiatric unit certified pursuant to paragraph 79.1(5)“r,” and the admission is medically appropriate, then payment for time spent in the unit is through a per diem. The discharging hospital will receive 100 percent of the DRG payment. When a patient is discharged from a certified psychiatric unit and is admitted to an acute care hospital, the acute care hospital will receive 100 percent of the DRG payment.

When a patient requiring psychiatric care is discharged from a facility other than an acute care hospital and is admitted to a psychiatric unit certified pursuant to paragraph 79.1(5)“r,” and the admission is medically appropriate, then payment for time spent in the unit is based on a per diem. The other facility will receive payment in accordance with rules governing that facility. When a patient is discharged from a certified psychiatric unit and is admitted to a facility other than an acute care hospital, the other facility will receive payment in accordance with rules governing that facility.

(5) Inpatient readmissions within 30 days for same condition. When an inpatient is discharged or transferred from an acute care hospital and is readmitted as an inpatient to the same hospital within 30 days for the same condition, any claim for the subsequent inpatient stay will be combined with the claim for the original inpatient stay and payment will be under a single DRG for both stays. The readmission policy does not apply to the following:

1. Scheduled readmissions that are part of repetitive or periodic treatments; and
2. Critical access hospitals.

h. Covered DRGs. Medicaid DRGs cover services provided in acute care general hospitals, with the exception of services provided in physical rehabilitation hospitals and units certified pursuant to paragraph 79.1(5)“r,” and services provided in psychiatric units certified pursuant to paragraph 79.1(5)“r,” which are paid per diem, as specified in paragraph 79.1(5)“i.”

i. Payment for certified physical rehabilitation hospitals and units, psychiatric units, and acute psychiatric intensive care services. Payment for services provided by a physical rehabilitation hospital or unit certified pursuant to paragraph 79.1(5)“r” and for services provided in a psychiatric unit certified pursuant to paragraph 79.1(5)“r” is prospective. The payment is based on a per diem rate calculated for each hospital by establishing a base year per diem rate to which a factor to maintain expenditures within the amount appropriated to the department for this purpose is applied.

(1) Per diem calculation. The base rate will be the medical assistance per diem rate as determined by the individual hospital’s base year cost report pursuant to paragraph 79.1(5)“a.” No recognition will be given to the professional component of the hospital-based physicians except as noted under paragraph 79.1(5)“j.”

(2) Per diem reimbursement. Hospitals will be reimbursed the lower of actual charges or the medical assistance cost per diem rate. The determination of the applicable rate will be based on the hospital fiscal year aggregate of actual charges and medical assistance cost per diem rate. If an overpayment exists, the hospital will refund or have the overpayment deducted from subsequent billings.

(3) Per diem recalculation. Hospital prospective reimbursement rates will be established based on the state’s fiscal year.

(4) Acute psychiatric intensive care services. Services that meet the criteria at 441—subrule 78.3(8) will be reimbursed as follows:

1. Services provided in a psychiatric unit certified pursuant to paragraph 79.1(5) “r” will be paid based on the hospital-specific per diem rate as calculated pursuant to subparagraph 79.1(5) “i”(1) plus a percentage increase as determined by the department for covered days billed with the appropriate psychiatric intensive care revenue code.

2. Services not provided in a psychiatric unit certified pursuant to paragraph 79.1(5) “r” will be paid based on the hospital-specific DRG payment rate as calculated pursuant to paragraph 79.1(5) “b” plus an add-on per diem rate as determined by the department for covered days billed with the appropriate psychiatric intensive care revenue code.

(5) Per diem billing. The current method for submitting billing and cost reports will be maintained. All cost reports will be subject to desk review audit and, if necessary, a field audit.

j. Services covered by DRG payments. Medicaid adopts the Medicare definition of inpatient hospital services covered by the DRG prospective payment system except as indicated herein. As a result, combined billing for physician services is eliminated unless the hospital has approval from Medicare to combine bill the physician and hospital services. Teaching hospitals having Medicare’s approval to receive reasonable cost reimbursement for physician services under 42 CFR 415 as amended to July 1, 2026, are eligible for combined billing status if they have the Medicare approval notice on file with Iowa Medicaid as verification. Reasonable cost settlement will be made during the year-end settlement process. Services provided by certified nurse anesthetists (CRNAs) employed by a physician are covered by the physician reimbursement. Payment for the services of CRNAs employed by the hospital are included in the hospital’s reimbursement.

The cost for hospital-based ambulance transportation that results in an inpatient admission and hospital-based ambulance services performed while the recipient is an inpatient, in addition to all other inpatient services, is covered by the DRG payment. If, during the inpatient stay at the originating hospital, it becomes necessary to transport but not transfer the patient to another hospital or provider for treatment, with the patient remaining an inpatient at the originating hospital after that treatment, the originating hospital shall bear all costs incurred by that patient for the medical treatment or the ambulance transportation between the originating hospital and the other provider. The services furnished to the patient by the other provider shall be the responsibility of the originating hospital. Reimbursement to the originating hospital for all services is under the DRG payment.

k. Inflation factors, rebasing, and recalibration.

(1) Inflation factors will be set annually at levels that ensure payments that are consistent with efficiency, economy, and quality of care and that are sufficient to enlist enough providers so that care and services are available at least to the extent that such care and services are available to the general population in the geographic area.

(2) Base amounts will be rebased and weights recalibrated in 2021 and every three years thereafter. Cost reports used in rebasing will be the hospital fiscal year-end Form CMS 2552, Hospital and Healthcare Complex Cost Report, as submitted to Medicare in accordance with Medicare cost report submission time lines for the hospital fiscal year ending during the calendar year preceding the rebasing implementation year. If a hospital does not provide this cost report to Iowa Medicaid by May 31 of a rebasing implementation year, the most recent submitted cost report will be used with the addition of a hospital market basket index inflation factor.

(3) The graduate medical education and disproportionate share fund will be updated as provided in subparagraphs 79.1(5) “y”(3), “y”(6), and “y”(9).

(4) Hospitals receiving reimbursement as critical access hospitals will not receive inflation of base payment amounts and will not have base amounts rebased or weights recalibrated pursuant to this paragraph.

l. Eligibility and payment. When a client is eligible for Medicaid for less than or equal to the average length of stay for that DRG, then payment equals 100 percent of the hospital’s average daily rate times the number of eligible hospital stay days up to the amount of the DRG payment. When a

Medicaid client is eligible for greater than the average length of stay but less than the entire stay, then payment is treated as if the client were eligible for the entire length of stay.

Long stay outlier days are determined as the number of Medicaid eligible days beyond the outlier limits. The date of patient admission is the first date of service. Long stay outlier costs are accrued only during eligible days.

m. Payment to out-of-state hospitals. Payment made to out-of-state hospitals providing care to beneficiaries of Iowa's Medicaid program is equal to either the Iowa statewide average blended base amount plus the statewide average capital cost add-on, multiplied by the DRG weight, or blended base and capital rates calculated by using 80 percent of the hospital's submitted capital costs. Hospitals that submit a cost report no later than May 31 in the most recent rebasing year will receive a case-mix-adjusted blended base rate using hospital-specific, Iowa-only Medicaid data and the Iowa statewide average cost per discharge amount.

(1) Capital costs will be reimbursed at either the statewide average rate in place at the time of discharge, or the blended capital rate computed by using submitted cost report data.

(2) Out-of-state hospitals do not qualify for disproportionate share payments.

(3) Out-of-state hospitals do not qualify for direct medical education or indirect medical education payments pursuant to paragraph 79.1(5) "y."

n. Preadmission, preauthorization, or inappropriate services. Medicaid adopts most Medicare regulations to control increased admissions or reduced services. Exceptions to the Medicare review practice are that Iowa Medicaid reviews short stay outliers and all Medicaid patients readmitted within 31 days. Payment can be denied if either admissions or discharges are performed without medical justification as determined by Iowa Medicaid. Inpatient or outpatient services that require preadmission or preprocedure approval by Iowa Medicaid are updated yearly by the department and are listed in the provider manual. Preauthorization for any of these services is transmitted directly to Iowa Medicaid and no additional information needs to be submitted as part of the claim filing for inpatient or outpatient services. To safeguard against these and other inappropriate practices, the department through Iowa Medicaid will monitor admission practices and quality of care. If an abuse of the prospective payment system is identified, payments for abusive practices may be reduced or denied. In reducing or denying payment, Medicaid adopts the Medicare regulations.

o. Hospital billing. Hospitals shall normally submit claims for DRG reimbursement to Iowa Medicaid after a patient's discharge.

(1) Payment for outlier days or costs is determined when the claim is paid by Iowa Medicaid as described in paragraph 79.1(5) "f."

(2) When a Medicaid patient requires acute care in the same facility for a period of no less than 120 days, a request for partial payment may be made. Written requests for this interim DRG payment shall be addressed to Iowa Medicaid at the department's address. A request for interim payment shall include:

1. The patient's name, state identification number, and date of admission;
2. A brief summary of the case;
3. A current listing of charges; and
4. A physician's attestation that the recipient has been an inpatient for 120 days and is expected to remain in the hospital for a period of no less than 60 additional days.

A departmental representative will then contact the facility to assist the facility in filing the interim claim.

p. Determination of inpatient admission. A person is considered to be an inpatient when a formal inpatient admission occurs, when a physician intends to admit a person as an inpatient, or when a physician determines that a person being observed as an outpatient in an observation or holding bed should be admitted to the hospital as an inpatient.

(1) In cases involving outpatient observation status, the determinant of patient status is not the length of time the patient was being observed, but rather that the observation period was medically

necessary for the physician to determine whether a patient should be released from the hospital or admitted to the hospital as an inpatient.

(2) Outpatient observation lasting greater than a 24-hour period will be subject to review by Iowa Medicaid to determine the medical necessity of each case. For those outpatient observation cases where medical necessity is not established by Iowa Medicaid, reimbursement will be denied for the services found to be unnecessary for the provision of that care, such as the use of the observation room.

q. Inpatient admission after outpatient services. A patient may be admitted to the hospital as an inpatient after receiving outpatient services. If the patient is admitted as an inpatient within three days of the day outpatient services were rendered, all outpatient services related to the principal diagnosis are considered inpatient services for billing purposes. The day of formal admission as an inpatient is considered as the first day of hospital inpatient services.

r. Certification for reimbursement as a special unit or physical rehabilitation hospital. Certification for Medicaid reimbursement as a substance abuse unit under subparagraph 79.1(5)“b”(1), a neonatal intensive care unit under subparagraph 79.1(5)“b”(2), a psychiatric unit under paragraph 79.1(5)“i,” or a physical rehabilitation hospital or unit under paragraph 79.1(5)“i” will be awarded as provided in this paragraph.

(1) Certification procedure. All hospital special units and physical rehabilitation hospitals must be certified by Iowa Medicaid to qualify for Medicaid reimbursement as a special unit or physical rehabilitation hospital. Hospitals shall submit requests for certification to Iowa Medicaid at the department’s address, with documentation that the certification requirements are met. Iowa Medicaid will notify the facility of any additional documentation needed after review of the submitted documentation.

Upon certification, reimbursement as a special unit or physical rehabilitation hospital will be retroactive to the first day of the month during which Iowa Medicaid received the request for certification. No additional retroactive payment adjustment will be made when a hospital fails to make a timely request for certification.

(2) Certification criteria for substance abuse units. An in-state substance abuse unit may be certified for Medicaid reimbursement under subparagraph 79.1(5)“b”(1) if the unit’s program is licensed by the department as a substance abuse treatment program in accordance with Iowa Code chapter 125. In addition to documentation of the license, an in-state hospital must submit documentation of the specific substance abuse programs available at the facility with a description of their staffing, treatment standards, and population served.

An out-of-state substance abuse unit may be certified for Medicaid reimbursement under subparagraph 79.1(5)“b”(1) if it is excluded from the Medicare prospective payment system as a psychiatric unit pursuant to 42 CFR Sections 412.25 and 412.27 as amended to July 1, 2026. An out-of-state hospital requesting reimbursement as a substance abuse unit must initially submit a copy of its current Medicare prospective payment system exemption notice unless the facility had certification for reimbursement as a substance abuse unit before July 1, 1993. All out-of-state hospitals certified for reimbursement for substance abuse units must submit copies of new Medicare prospective payment system exemption notices as they are issued, at least annually.

(3) Certification criteria for neonatal intensive care units. A neonatal intensive care unit may be certified for Medicaid reimbursement under subparagraph 79.1(5)“b”(2) if it is certified as a level II or level III neonatal unit and the hospital where it is located is accredited by the Joint Commission or the American Osteopathic Association. Iowa Medicaid will verify the unit’s certification as a level II or level III neonatal unit in accordance with recommendations set forth by the American Academy of Pediatrics for newborn care. Neonatal units in Iowa shall be certified by the department pursuant to 641—Chapter 150. Out-of-state units shall submit proof of level II or level III certification.

(4) Certification criteria for psychiatric units. A psychiatric unit may be certified for Medicaid reimbursement under paragraph 79.1(5)“i” if it is excluded from the Medicare prospective payment

system as a psychiatric unit pursuant to 42 CFR Sections 412.25 and 412.27 as amended to July 1, 2026.

(5) Certification criteria for physical rehabilitation hospitals and units. A physical rehabilitation hospital or unit may be certified for Medicaid reimbursement under paragraph 79.1(5)“i” if the physical rehabilitation hospital or unit receives or qualifies to receive Medicare reimbursement as a rehabilitative hospital or unit pursuant to 42 CFR Subpart P as amended to July 1, 2026, and the hospital is accredited by the Joint Commission or the American Osteopathic Association.

s. Health care access assessment inflation factor. Effective with the implementation of the health care access assessment paid pursuant to 441—Chapter 36, a health care access assessment inflation factor will be applied to the Medicaid DRG blended base amount as otherwise calculated pursuant to this subrule for all “participating hospitals” as defined in 441—subrule 36.5(1).

(1) Calculation of inflation factor. The health care access assessment inflation factor for participating hospitals will be calculated by dividing the amount allowed under the Medicare inpatient upper payment limit for the fiscal year beginning July 1, 2010, by the sum of the projected expenditures for participating hospitals for the fiscal year beginning July 1, 2010, as determined by the department, and the amount allowed under the Medicare inpatient upper payment limit.

(2) Implementation date. The health care access assessment inflation factor will not be applied until federal financial participation to match money collected from the health care access assessment pursuant to 441—Chapter 36 has been approved by the federal Centers for Medicare and Medicaid Services.

(3) End date. Application of the health care access assessment inflation factor will terminate if the health care access assessment is terminated. If federal match money is unavailable for a retroactive period or the authority to collect the assessment is rescinded for a retroactive period, the department will:

1. Recalculate Medicaid rates in effect during that period without the application of the health care access assessment inflation factor;
2. Recompute Medicaid payments due based on the recalculated Medicaid rates;
3. Recoup any previous overpayments; and
4. Determine for each hospital the amount of health care access assessment collected during that period and refund that amount to the facility.

t. Limitations and application of limitations on payment. Diagnosis-related group payments are subject to the upper payment limits as stated in 42 CFR 447.271 and 42 CFR 447.272, both as amended to July 1, 2026.

(1) The department may not pay a provider more for inpatient hospital services under Medicaid than the provider’s customary charges to the general public for the services. This limit is applied in the aggregate during the cost settlement process at the end of the hospital’s fiscal year.

(2) Aggregate payments to hospitals and state-operated hospitals may not exceed the amount that can reasonably be estimated would have been paid for those services under Medicare payment principles. This limit is applied to aggregate Medicaid payments at the end of the state’s fiscal year.

u. State-owned teaching hospital disproportionate share payment. In addition to payments from the graduate medical education and disproportionate share fund made pursuant to paragraph 79.1(5)“y,” payment will be made to Iowa hospitals qualifying for the Iowa state-owned teaching hospital disproportionate share fund. Interim monthly payments based on estimated allowable costs will be paid to qualifying hospitals under this paragraph.

(1) Qualifying criteria. A hospital qualifies for Iowa state-owned teaching hospital disproportionate share payments if it qualifies for disproportionate share payments pursuant to paragraph 79.1(5)“y” and is an Iowa state-owned hospital with more than 500 beds and eight or more distinct residency specialty or subspecialty programs recognized by the American Council on Graduate Medical Education.

(2) Allocation to fund. The total amount of funding that is allocated on July 1 of each year to the Iowa state-owned teaching hospital disproportionate share fund is \$0.

(3) Amount of payment. The total amount of disproportionate share payments from the graduate medical education and disproportionate share fund and from the Iowa state-owned teaching hospital disproportionate share fund shall not exceed the amount of the state's allotment under Public Law 102-234 as amended to July 1, 2026. In addition, the total amount of all disproportionate share payments shall not exceed the hospital-specific disproportionate share limits under Public Law 103-666 as amended to July 1, 2026.

(4) Final disproportionate share adjustment. The department's total year-end disproportionate share obligations to a qualifying hospital will be calculated following completion of the desk review or audit of CMS 2552, Hospital and Healthcare Complex Cost Report.

v. *Non-state-owned teaching hospital disproportionate share payment.* In addition to payments from the graduate medical education and disproportionate share fund made pursuant to paragraph 79.1(5) "y," payment will be made to Iowa hospitals qualifying for Iowa non-state-government-owned acute care teaching hospital disproportionate share payments. Interim monthly payments based on estimated allowable costs will be paid to qualifying hospitals under this paragraph.

(1) Qualifying criteria. A hospital qualifies for the Iowa non-state-government-owned acute care teaching hospital disproportionate share payments if it qualifies for disproportionate share payments pursuant to paragraph 79.1(5) "y" and is an Iowa non-state-government-owned acute care teaching hospital located in a county with a population over 350,000.

(2) Amount of payment. The total amount of disproportionate share payments pursuant to paragraph 79.1(5) "y" and the Iowa non-state-government-owned acute care teaching hospital disproportionate share payments will not exceed the amount of the state's allotment under Public Law 102-234 as amended to July 1, 2026. In addition, the total amount of all disproportionate share payments will not exceed the hospital-specific disproportionate share limits under Public Law 103-666 as amended to July 1, 2026.

(3) Final disproportionate share adjustment. The department's total year-end disproportionate share obligations to a qualifying hospital will be calculated following completion of the desk review or audit of CMS 2552, Hospital and Healthcare Complex Cost Report.

w. *Rate adjustments for hospital mergers.* When one or more hospitals merge to form a distinctly different legal entity, the base rate plus applicable add-ons will be revised to reflect this new entity. Financial information from the original cost reports and original rate calculations will be added together and averaged to form the new rate for that entity.

x. Reportable Medicaid administrative and general expenses are allowable only to the extent that they are defined as allowable using Medicare Reimbursement Principles or Health Insurance Reimbursement Manual 15 (HIM-15) as amended to July 1, 2026. Appropriate, reportable costs are those that meet the Medicare (or HIM-15) principles, are reasonable, and are directly related to patient care. In instances where costs are not directly related to patient care or are not in accord with Medicare Principles of Reimbursement, inclusion of those costs in the cost report would not be appropriate. Examples of administrative and general costs that must be related to patient care to be included as a reportable cost in the report are:

- (1) Advertising.
- (2) Promotional items.
- (3) Feasibility studies.
- (4) Administrative travel and entertainment.
- (5) Dues, subscriptions, or membership costs.
- (6) Contributions made to other organizations.
- (7) Home office costs.
- (8) Public relations items.
- (9) Any patient convenience items.
- (10) Management fees for administrative services.
- (11) Luxury employee benefits (i.e., country club dues).
- (12) Motor vehicles for other than patient care.

(13) Reorganization costs.

y. *Graduate medical education and disproportionate share fund.* Payment will be made to hospitals in Iowa qualifying for direct medical education, indirect medical education, or disproportionate share payments directly from the graduate medical education and disproportionate share fund. The requirements to receive payments from the fund, the amounts allocated to the fund, and the methodology used to determine the distribution amounts from the fund are as follows:

(1) Qualifying for direct medical education. Iowa hospitals qualify for direct medical education payments if direct medical education costs that qualify for payment as medical education costs under the Medicare program are contained in the hospital's base year cost report and in the most recent cost report submitted before the start of the state fiscal year for which payments are being made. Out-of-state hospitals do not qualify for direct medical education payments.

(2) Allocation to fund for direct medical education. The total state fiscal year annual amount of funding that is allocated to the graduate medical education and disproportionate share fund for direct medical education related to inpatient services is \$7,594,294.03. If a hospital fails to qualify for direct medical education payments from the fund because the hospital does not report direct medical education costs that qualify for payment as medical education costs under the Medicare program in the most recent cost report submitted before the start of the state fiscal year for which payments are being made, the amount of money that would have been paid to that hospital will be removed from the fund.

(3) Distribution to qualifying hospitals for direct medical education. Distribution of the amount in the fund for direct medical education will be on a monthly basis. To determine the amount to be distributed to each qualifying hospital for direct medical education, the following formula is used:

1. Multiply the total of all DRG weights pursuant to paragraph 79.1(5) "r" for claims paid from the GME/DSH fund apportionment claim set for each hospital reporting direct medical education costs that qualify for payment as medical education costs under the Medicare program in the hospital's base year cost report by each hospital's direct medical education rate to obtain a dollar value.

2. Sum the dollar values for each hospital, then divide each hospital's dollar value by the total dollar value, resulting in a percentage.

3. Multiply each hospital's percentage by the amount allocated for direct medical education to determine the payment to each hospital.

(4) Qualifying for indirect medical education. Iowa hospitals qualify for indirect medical education payments from the fund when they receive a direct medical education payment from Iowa Medicaid and qualify for indirect medical education payments from Medicare. Qualification for indirect medical education payments is determined without regard to the individual components of the specific hospital's teaching program, state ownership, or bed size. Out-of-state hospitals do not qualify for indirect medical education payments.

(5) Allocation to fund for indirect medical education. The total state fiscal year annual amount of funding that is allocated to the graduate medical education and disproportionate share fund for indirect medical education related to inpatient services is \$13,450,285.14. If a hospital fails to qualify for indirect medical education payments from the fund because the hospital does not report direct medical education costs that qualify for payment as medical education costs under the Medicare program in the most recent cost report submitted before the start of the state fiscal year for which payments are being made, the amount of money that would have been paid to that hospital will be removed from the fund.

(6) Distribution to qualifying hospitals for indirect medical education. Distribution of the amount in the fund for indirect medical education will be on a monthly basis. To determine the amount to be distributed to each qualifying hospital for indirect medical education, the following formula is used:

1. Multiply the total of all DRG weights, pursuant to paragraph 79.1(5) "r," for claims paid from the GME/DSH fund apportionment claim set for each hospital reporting direct medical education costs that qualify for payment as medical education costs under the Medicare program in the hospital's base year cost report by each hospital's indirect medical education rate to obtain a dollar value.

2. Sum the dollar values for each hospital, then divide each hospital's dollar value by the total dollar value, resulting in a percentage.

3. Multiply each hospital's percentage by the amount allocated for indirect medical education to determine the payment to each hospital.

(7) Qualifying for disproportionate share. Hospitals qualify for disproportionate share payments from the fund when the hospital's low-income utilization rate exceeds 25 percent, when the hospital's Medicaid inpatient utilization rate exceeds one standard deviation from the statewide average Medicaid utilization rate, or when the hospital qualifies as a children's hospital under subparagraph 79.5(1) "y"(10). Information contained in the hospital's base year cost report is used to determine the hospital's low-income utilization rate and the hospital's Medicaid inpatient utilization rate.

1. For those hospitals that qualify for disproportionate share under both the low-income utilization rate definition and the Medicaid inpatient utilization rate definition, the disproportionate share percentage will be the greater of (1) the product of 2½ percent multiplied by the number of standard deviations by which the hospital's own Medicaid inpatient utilization rate exceeds the statewide mean Medicaid inpatient utilization rate for all hospitals or (2) 2 ½ percent.

2. For those hospitals that qualify for disproportionate share under the low-income utilization rate definition but do not qualify under the Medicaid inpatient utilization rate definition, the disproportionate share percentage will be 2½ percent.

3. For those hospitals that qualify for disproportionate share under the Medicaid inpatient utilization rate definition but do not qualify under the low-income utilization rate definition, the disproportionate share percentage will be the product of 2½ percent multiplied by the number of standard deviations by which the hospital's own Medicaid inpatient utilization rate exceeds the statewide mean Medicaid inpatient utilization rate for all hospitals.

4. For those hospitals that qualify for disproportionate share as a children's hospital, the disproportionate share percentage will be the greater of (1) the product of 2½ percent multiplied by the number of standard deviations by which the Medicaid inpatient utilization rate for children under 18 years of age at the time of admission in all areas of the hospital where services are provided predominantly to children under 18 years of age exceeds the statewide mean Medicaid inpatient utilization rate for all hospitals or (2) 2½ percent.

5. Additionally, a qualifying hospital other than a children's hospital must also have at least two obstetricians who have staff privileges at the hospital and who have agreed to provide obstetric services to Medicaid-eligible persons who are in need of obstetric services. In the case of a hospital located in a rural area as defined in Section 1886 of the Social Security Act as amended to July 1, 2026, the term "obstetrician" includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures.

6. Out-of-state hospitals serving Iowa Medicaid patients qualify for disproportionate share payments from the fund based on their state Medicaid agency's calculation of the Medicaid inpatient utilization rate. The disproportionate share percentage is calculated using the number of standard deviations by which the hospital's own state Medicaid inpatient utilization rate exceeds the hospital's own statewide mean Medicaid inpatient utilization rate.

7. Hospitals qualify for disproportionate share payments from the fund without regard to the facility's status as a teaching facility or bed size.

8. Hospitals receiving reimbursement as critical access hospitals do not qualify for disproportionate share payments from the fund.

(8) Allocation to fund for disproportionate share. The total state fiscal year annual amount of funding that is allocated to the graduate medical education and disproportionate share fund for disproportionate share payments is \$6,959,868.59. If a hospital fails to qualify for disproportionate share payments from the fund due to closure or for any other reason, the amount of money that would have been paid to that hospital will be removed from the fund.

(9) Distribution to qualifying hospitals for disproportionate share. Distribution of the amount in the fund for disproportionate share will be on a monthly basis. To determine the amount to be distributed to each qualifying hospital for disproportionate share, the following formula is used:

1. Multiply the total of all DRG weights, pursuant to paragraph 79.1(5) “r,” for claims paid from the GME/DSH fund apportionment claim set for each hospital that met the qualifications during the fiscal year used to determine the hospital’s low-income utilization rate and Medicaid utilization rate (or for children’s hospitals, during the preceding state fiscal year) by each hospital’s disproportionate share rate to obtain a dollar value. For any hospital that qualifies for a disproportionate share payment only as a children’s hospital, only the DRG weights, pursuant to 79.1(5) “r,” for services rendered to patients under 18 years of age at the time of admission in all distinct areas of the hospital where services are provided predominantly to children under 18 years of age will be used in this calculation.

2. Sum the dollar values for each hospital, then divide each hospital’s dollar value by the total dollar value, resulting in a percentage.

3. Multiply each hospital’s percentage by the amount allocated for disproportionate share to determine the payment to each hospital.

In compliance with Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991 (Public Law 102-234 as amended to July 1, 2026) and 1992 Iowa Acts, chapter 1246, section 13, the total of disproportionate share payments from the GME/DSH fund and supplemental disproportionate share of payments, pursuant to paragraph 79.1(5) “u” or 79.1(5) “v,” cannot exceed the amount of the federal cap under Public Law 102-234 as amended to July 1, 2026.

(10) Qualifying for disproportionate share as a children’s hospital. A licensed hospital qualifies for disproportionate share payments as a children’s hospital if the hospital provides services predominantly to children under 18 years of age or includes a distinct area or areas providing services predominantly to children under 18 years of age and has Medicaid utilization and low-income utilization rates of 1 percent or greater for children under 18 years of age at the time of admission in all distinct areas of the hospital where services are provided predominantly to children under 18 years of age. In addition, the hospital must be a voting member of the National Association of Children’s Hospitals and Related Institutions for dates of service prior to October 1, 2014, or a member of the National Association of Children’s Hospitals and Related Institutions.

A hospital wishing to qualify for disproportionate share payments as a children’s hospital must provide the following information to Iowa Medicaid within 20 business days of a request by the department:

1. Base year cost reports.
2. Medicaid claims data for children under the age of 18 at the time of admission to the hospital in all distinct areas of the hospital where services are provided predominantly to children under 18 years of age.
3. Other information needed to determine a disproportionate share rate encompassing the periods used to determine the disproportionate share rate and distribution amounts.

z. Reserved.

aa. Retrospective adjustment for critical access hospitals. Payments to critical access hospitals, pursuant to paragraphs 79.1(5) “a” through “z,” are subject to a retrospective adjustment equal to the difference between the reasonable costs of covered services provided to eligible fee-for-service Medicaid members (excluding members in managed care), based on the hospital’s annual cost reports and Medicare cost principles, and the Medicaid fee-for-service reimbursement received pursuant to paragraphs 79.1(5) “a” through “z.” Amounts paid before adjustment that exceed reasonable costs will be recovered by the department.

(1) The base rate upon which the DRG payment is built will be changed after any retrospective adjustment to reflect, as accurately as is possible, the reasonable costs of providing the covered service to eligible fee-for-service Medicaid members for the coming year using the most recent utilization as submitted to Iowa Medicaid and Medicare cost principles.

(2) Once a hospital begins receiving reimbursement as a critical access hospital, the prospective DRG base rate is not subject to inflation factors, rebasing, or recalibration as provided in paragraph 79.1(5) “k.”

ab. Nonpayment for preventable conditions. Preventable conditions identified pursuant to this rule that develop during inpatient hospital treatment will not be considered in determining reimbursement for such treatment.

(1) Coding. All diagnoses included on an inpatient hospital claim must include one of the following codes indicating whether the condition was present or developing at the time of the order for inpatient admission:

Present on Admission (POA) Indicator Codes

Code	Explanation

Y	The condition was present or developing at the time of the order for inpatient admission.
N	The condition was not present or developing at the time of the order for inpatient admission.
U	Documentation is insufficient to determine whether the condition was present or developing at the time of the order for inpatient admission.
W	Clinically undetermined. The provider is clinically unable to determine whether or not the condition was present or developing at the time of the order for inpatient admission.

(2) Payment processing. Claims will be processed according to the DRG methodology without consideration of any diagnosis identified by the Secretary of the United States Department of Health and Human Services, pursuant to Section 1886(d)(4)(D)(iv) of the Social Security Act (42 U.S.C. 1395ww(d)(4)(D)(iv) as amended to July 1, 2026, if the condition was not present or developing at the time of the order for inpatient admission.

ac. Rural hospital disproportionate share payment. In addition to payments from the graduate medical education and disproportionate share fund made pursuant to paragraph 79.1(5)“y,” payment will be made to qualifying Iowa hospitals that elect to participate in rural hospital disproportionate share payments. Interim monthly payments will be made based on the amount of state share that is transferred to the department.

(1) Qualifying criteria. A hospital that qualifies for disproportionate share payments pursuant to paragraph 79.1(5)“y” and that is a rural prospective payment hospital not designated as a critical access hospital qualifies for rural hospital disproportionate share payments.

(2) Source of nonfederal share. The required nonfederal share will be funds generated from tax levy collections of the county or city in which the hospital is located and is subject to the conditions specified in this subparagraph and applicable federal law and regulations.

1. The nonfederal share funds shall be distributed to the department prior to the issuance of any disproportionate share payment to a qualifying hospital.

2. The city or county providing the nonfederal share funds shall annually document and certify that the funds provided as the nonfederal share were generated from tax proceeds, and not from any other source including federal grants or another federal funding source.

3. The applicable federal matching rate for the fiscal year will apply.

(3) Amount of payment. The total amount of disproportionate share payments made, pursuant to paragraph 79.1(5)“y,” and the rural hospital disproportionate share payments will not exceed the amount of the state’s allotment under Public Law 102-234 as amended to July 1, 2026. In addition, the total amount of all disproportionate share payments will not exceed the hospital-specific disproportionate share limits under Public Law 103-666 as amended to July 1, 2026.

(4) Final disproportionate share adjustment. Qualifying hospitals shall annually provide a disproportionate share hospital survey within the time frames specified by the department for the purpose of calculating the hospital-specific disproportionate share limits under Public Law 103-666 as amended to July 1, 2026.

79.1(6) Independent laboratories. The maximum payment for clinical diagnostic laboratory tests performed by an independent laboratory will be the areawide fee schedule established by the Centers for Medicare and Medicaid Services (CMS). The fee schedule is based on the definition of laboratory procedures from the Physician’s Current Procedural Terminology (CPT) published by the American

Medical Association as amended to July 1, 2026. The fee schedules are adjusted annually by CMS to reflect changes in the Consumer Price Index for All Urban Consumers.

79.1(7) Physicians.

a. Fee schedule. The fee schedule is based on the definitions of medical and surgical procedures given in the CPT as amended to July 1, 2026. Refer to 441—paragraph 78.1(2)“e” for the guidelines for immunization replacement.

b. Payment reduction for services rendered in facility settings. The fee schedule amount paid to physicians based on paragraph 79.1(7)“a” will be reduced by an adjustment factor, as determined by the department and published with the Iowa Medicaid fee schedule, to reflect the lower cost of providing physician services in a facility setting as opposed to the physician’s office. For the purpose of this provision, a “facility” place of service (POS) is defined as any of the following (consistent with “POS” definitions under Medicare per the Medicare Claims Processing Manual, Chapter 12, Section 20.4.2, amended to July 1, 2026):

- (1) Telehealth (POS 02).
- (2) Outpatient hospital-off campus (POS 19).
- (3) Inpatient hospital (POS 21).
- (4) Outpatient hospital-on campus (POS 22).
- (5) Emergency room-hospital (POS 23).
- (6) Ambulatory surgical center (POS 24).
- (7) Military treatment center (POS 26).
- (8) Skilled nursing facility (POS 31).
- (9) Hospice-for inpatient care (POS 34).
- (10) Ambulance-land (POS 41).
- (11) Ambulance-air or water (POS 42).
- (12) Inpatient psychiatric facility (POS 51).
- (13) Psychiatric facility-partial hospitalization (POS 52).
- (14) Community mental health center (POS 53).
- (15) Psychiatric residential treatment center (POS 56).
- (16) Comprehensive inpatient rehabilitation (POS 61).

c. Payment for primary care services. Primary care services that are eligible for payment, pursuant to this rule, will be paid at the greater of:

- (1) The otherwise applicable Iowa Medicaid rate;
- (2) The applicable rate under Medicare Part B in effect for services rendered on January 1, 2014;
- (3) The rate that would be applicable under Medicare Part B, in effect for services rendered on January 1, 2014, if the conversion factor under 42 U.S.C. §1395w-4(d) as amended to July 1, 2026, were the conversion factor for 2009; or
- (4) If there is no applicable rate under Medicare Part B, the rate specified in a fee schedule established and announced by the CMS, pursuant to 42 CFR §447.405(a)(1), and in effect on June 30, 2014.

Notwithstanding the foregoing provisions of this paragraph (79.1(7)“c”), payment for the administration of vaccines provided under the Vaccines for Children Program will be the lesser of:

1. The regional maximum administration fee under the Vaccines for Children Program in effect on June 30, 2014; or
2. The applicable Medicare fee schedule rate in effect on June 30, 2014, for HCPCS code 90460 (or, if higher, the Medicare fee schedule rate for HCPCS code 90460 rate that would apply if the conversion factor under 42 U.S.C. §1395w-4(d) as amended to July 1, 2026, were the conversion factor for 2009).

d. Payment for anesthesia services. Anesthesia services are paid pursuant to this paragraph and the Iowa Medicaid fee schedule published by the department pursuant to paragraph 79.1(1)“c.” Anesthesia procedures listed in the fee schedule with a factor code of “F” are paid at the dollar amount of the factor listed for the procedure in the fee schedule. Anesthesia procedures listed in the fee

schedule with a factor code of “A” are paid a dollar amount equal to the Iowa Medicaid anesthesia conversion factor multiplied by the sum of the minutes of service provided and the factor listed for the procedure in the fee schedule. The Iowa Medicaid anesthesia conversion factor is the current Medicare anesthesia conversion factor for Iowa, converted to a per-minute amount, which will be updated annually on January 1.

79.1(8) Drugs.

a. Except as provided in paragraphs 79.1(8)“*d*” through “*h*,” all providers are reimbursed for covered drugs as follows:

(1) Reimbursement for covered generic prescription drugs and for covered nonprescription drugs will be the lowest of the following, as of the date of dispensing:

1. The average state actual acquisition cost (AAC), determined pursuant to paragraph 79.1(8)“*b*,” plus the professional dispensing fee, determined pursuant to paragraph 79.1(8)“*c*”;

2. The federal upper limit (FUL), defined as the upper limit for a multiple-source drug established in accordance with the methodology of CMA as described in 42 CFR 447.514(a)-(c) as amended to July 1, 2026, plus the professional dispensing fee determined pursuant to paragraph 79.1(8)“*c*”;

3. The total submitted charge, represented by the lower of the gross amount due (GAD) as defined by the National Council for Prescription Drug Programs (NCPDP) standards definition, or the ingredient cost submitted plus the state defined professional dispensing fee, determined pursuant to paragraph 79.1(8)“*c*”; or

4. Providers’ usual and customary charge to the general public.

(2) Reimbursement for covered brand-name prescription drugs will be the lowest of the following, as of the date of dispensing:

1. The average state AAC, determined pursuant to paragraph 79.1(8)“*b*,” plus the professional dispensing fee, determined pursuant to paragraph 79.1(8)“*c*”;

2. The total submitted charge, represented by the lower of the GAD as defined by the NCPDP standards definition, or the ingredient cost submitted plus the state-defined professional dispensing fee; or

3. Providers’ usual and customary charge to the general public.

b. For purposes of this subrule, average state AAC is defined as retail pharmacies’ average prices paid to acquire drug products. Average state AAC will be determined by the department based on a survey of invoice prices paid by Iowa Medicaid retail pharmacies. Surveys will be conducted at least once every six months or more often at the department’s discretion. The average state AAC will be calculated as a statistical mean based on one reported cost per drug per pharmacy. The average state AAC determined by the department will be published on the department’s website. If no current average state AAC has been determined for a drug, the wholesale acquisition cost (WAC) published by Medi-Span will be used as the average state AAC.

c. Professional dispensing fee.

(1) For purposes of this subrule, the professional dispensing fee will be a fee schedule amount determined by the department based on a survey of Iowa Medicaid participating pharmacy providers’ costs of dispensing drugs to Medicaid beneficiaries. The survey will be conducted every two years beginning in state fiscal year 2014-2015.

(2) There is a one-time professional dispensing fee reimbursed per one-month or three-month period, accounting for the refill tolerance of 90 percent consumption, per member, per drug, per strength, billed per provider for maintenance drugs as identified by MediSpan and maintenance nonprescription drugs.

d. For an oral solid dispensed to a patient in a nursing home in unit dose packaging prepared by the pharmacist, an additional one cent per dose will be added to reimbursement based on acquisition cost or FUL. Payment may be made only for unit-dose-packaged drugs that are consumed by the patient. Any previous charges for unused unit-dose packages returned to the pharmacy must be credited to the Medicaid program, consistent with the board of pharmacy’s rules on return of drugs.

e. 340B-purchased drugs.

(1) Notwithstanding paragraph 79.1(8)“*a*,” reimbursement to a covered entity as defined in 42 U.S.C. 256b(a)(4) as amended to July 1, 2026, for covered outpatient drugs acquired by the entity through the 340B drug pricing program will be the lowest of:

1. The 340B covered entity actual acquisition cost (not to exceed the 340B ceiling price), submitted in the ingredient cost field, plus the professional dispensing fee pursuant to paragraph 79.1(8)“*c*”;

2. The average state AAC determined pursuant to paragraph 79.1(8)“*b*” plus the professional dispensing fee pursuant to paragraph 79.1(8)“*c*”;

3. For generic prescription drugs and nonprescription drugs only, the FUL pursuant to numbered paragraph 79.1(8)“*a*”(1)“2” plus the professional dispensing fee pursuant to paragraph 79.1(8)“*c*”;

4. The total submitted charge, represented by the GAD as defined by the NCPDP standards definition; or

5. Providers’ usual and customary charge to the general public.

(2) Reimbursement for covered outpatient drugs to a 340B contract pharmacy, under contract with a covered entity described in 42 U.S.C. 256b(a)(4) as amended to July 1, 2026, will be according to paragraph 79.1(8)“*a*” because covered outpatient drugs purchased through the 340B drug pricing program cannot be billed to Medicaid by a 340B contract pharmacy.

f. Federal supply schedule (FSS) drugs. Notwithstanding paragraph 79.1(8)“*a*” above, reimbursement for drugs acquired by a provider through the FSS program managed by the federal General Services Administration will be the lowest of:

(1) The provider’s actual acquisition cost (not to exceed the FSS price), submitted in the ingredient cost field, plus the professional dispensing fee pursuant to paragraph 79.1(8)“*c*”;

(2) The average state AAC determined pursuant to paragraph 79.1(8)“*b*” plus the professional dispensing fee pursuant to paragraph 79.1(8)“*c*”;

(3) For generic prescription drugs and nonprescription drugs only, the FUL pursuant to numbered paragraph 79.1(8)“*a*”(1)“2” plus the professional dispensing fee pursuant to paragraph 79.1(8)“*c*”;

(4) The total submitted charge, represented by the GAD as defined by the NCPDP standards definition; or

(5) Providers’ usual and customary charge to the general public.

g. Nominal-price drugs. Notwithstanding paragraph 79.1(8)“*a*” above, reimbursement for drugs acquired by providers at nominal prices and excluded from the calculation of the drug’s “best price” pursuant to 42 CFR 447.508 as amended to July 1, 2026, will be the lowest of:

(1) The provider’s actual acquisition cost (not to exceed the nominal price paid), submitted in the ingredient cost field, plus the professional dispensing fee pursuant to paragraph 79.1(8)“*c*”;

(2) The average state AAC determined pursuant to paragraph 79.1(8)“*b*” plus the professional dispensing fee pursuant to paragraph 79.1(8)“*c*”;

(3) For generic prescription drugs and nonprescription drugs only, the FUL pursuant to 79.1(8)“*a*”(1)“2” plus the professional dispensing fee pursuant to paragraph 79.1(8)“*c*”;

(4) The total submitted charge, represented by the GAD as defined by the NCPDP standards definition; or

(5) Providers’ usual and customary charge to the general public.

h. Indian health facilities enrolled pursuant to rule 441—77.47(249A). For all drugs provided to American Indians or Alaskan natives by Indian health facilities enrolled pursuant to rule 441—77.47(249A), reimbursement is one pharmacy encounter payment per date of service, notwithstanding paragraphs 79.1(8)“*a*” through “*f*.” The pharmacy encounter rate is the current “outpatient per visit rate (excluding Medicare)” approved by the U.S. Indian Health Service (IHS) for services provided by IHS facilities to Medicaid beneficiaries, as published in the Federal Register, as amended to July 1, 2026, and includes reimbursement for the dispensing fees, ingredient cost, and any necessary counseling by the pharmacist.

i. Physician-administered drugs. Notwithstanding paragraphs 79.1(8) “a” through “f,” payment to physicians for physician-administered drugs billed with healthcare common procedure coding system (HCPCS) Level II “J” codes, as a physician service, will be pursuant to the physician payment policy under subrule 79.1(2).

j. Under this subrule, no payment will be made for sales tax.

k. For purposes of this subrule, the Medicaid program relies on information published by Medi-Span to classify drugs as brand-name or generic.

79.1(9) Reserved.

79.1(10) *Prohibition against reassignment of claims.* No payment under the medical assistance program for any care or service provided to a patient by any health care provider will be made to anyone other than the providers. However, with respect to physicians, dentists or other individual practitioners, direct payment may be made to the employer of the practitioner if the practitioner is required as a condition of employment to turn over fees to the employer; or where the care or service was provided in a facility, to the facility in which the care or service was provided if there is a contractual arrangement between the practitioner and the facility whereby the facility submits the claim for reimbursement; or to a foundation, plan or similar organization, including a health maintenance organization that furnishes health care through an organized health care delivery system if there is a contractual agreement between organization and the person furnishing the service under which the organization bills or receives payment for the person’s services. Payment may be made in accordance with an assignment from the provider to a government agency or an assignment made pursuant to a court order. Payment may be made to a business agent, such as a billing service or accounting firm, that renders statements and receives payment in the name of the provider when the agent’s compensation for this service is (1) reasonably related to the cost or processing the billing; (2) not related on a percentage or other basis to the dollar amounts to be billed or collected; and (3) not dependent upon the actual collection of payment. Nothing in this rule will preclude making payment to the estate of a deceased practitioner.

79.1(11) *Prohibition against factoring.* Payment under the medical assistance program for any care or service furnished to an individual by providers, as specified in subrule 79.1(1), will not be made to or through a factor either directly or by virtue of power of attorney given by the provider to the factor. A factor is defined as an organization, collection agency, or service bureau that, or an individual who, advances money to a provider for accounts receivable that have been assigned or sold or otherwise transferred, including transfer through the use of power of attorney to the organization or individual for an added fee or reduction of a portion of the accounts receivable. The term factor does not include business representatives, such as billing agents or accounting firms, that render statements and receive payments in the name of the individual provider provided that the compensation of the business representative for the service is reasonably related to the cost of processing the billings and is not related on a percentage or other basis to the dollar amounts to be billed or collected.

79.1(12) *Reasonable charges for services, supplies, and equipment.* For selected medical services, supplies, and equipment, including equipment servicing, which, in the judgment of the Secretary of the Department of Health and Human Services, generally do not vary significantly in quality from one provider to another, the upper limits for payments will be the lowest charges for which the devices are widely and consistently available in a locality. For those selected services and items furnished under Part B of Medicare and Medicaid, the upper limits will be the lowest charge levels recognized under Medicare. For those selected services and items furnished only under Medicaid, the upper limits will be the lowest charge levels determined by the department according to the Medicare reimbursement method.

a. For any noninstitutional item or service furnished under both Medicare and Medicaid, the department will pay no more than the reasonable charge established for that item or service by the Part B Medicare carrier serving part or all of Iowa. Noninstitutional services do not include practitioner’s services, such as physicians, pharmacies, or out-patient hospital services.

b. For all other noninstitutional items or services furnished only under Medicaid, the department will pay no more than the customary charge for a provider or the prevailing charges in the locality for comparable items or services under comparable circumstances, whichever is lower.

79.1(13) Copayment by member. A copayment in the amount specified will be charged to members for the following covered services:

a. The member shall pay a copayment of \$1 for each covered prescription or refill of any covered drug.

b. The member shall pay \$1 copayment for total covered service rendered on a given date for podiatrists' services, chiropractors' services, and services of independently practicing physical therapists.

c. The member shall pay \$2 copayment for total covered services rendered on a given date for medical equipment and appliances, prosthetic devices and medical supplies as defined in rule 441—78.10(249A), orthopedic shoes, services of audiologists, services of hearing aid dealers except the hearing aid, services of optometrists, opticians, rehabilitation agencies, and psychologists, and ambulance services.

d. The member shall pay \$3 copayment for:

(1) Total covered service rendered on a given date for dental services and hearing aids.

(2) All covered services rendered in a physician office visit on a given date. For the purposes of this subparagraph, "physician" means either a doctor of allopathic medicine (M.D.) or a doctor of osteopathic medicine (D.O.), as defined under rule 441—77.1(249A).

e. Copayment charges are not applicable to persons under age 21.

f. Copayment charges are not applicable to family planning services or supplies.

g. Copayment charges are not applicable for a member receiving inpatient care in a hospital, nursing facility, state mental health institution, or other medical institution if the person is required, as a condition of receiving services in the institution, to spend for costs of necessary medical care all but a minimal amount of income for personal needs.

h. The member shall pay \$1 for each federal Medicare Part B crossover claim submitted to the Medicaid program when the services provided have a Medicaid copayment as set forth above.

i. Copayment charges are not applicable to services furnished pregnant women.

j. All providers are prohibited from offering or providing copayment related discounts, rebates, or similar incentives for the purpose of soliciting the patronage of Medicaid members.

k. Copayment charges are not applicable for emergency services. Emergency services are defined as services provided in a hospital, clinic, office, or other facility that is equipped to furnish the required care, after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain), that the absence of immediate medical attention could reasonably be expected to result in:

(1) Placing the patient's health in serious jeopardy,

(2) Serious impairment to bodily functions, or

(3) Serious dysfunction of any bodily organ or part.

l. Copayment charges are not applicable for services rendered by a health maintenance organization in which the member is enrolled.

m. No provider of service participating in the Medicaid program may deny care or services to a person eligible for care or services under the program because of the person's inability to pay a copayment. However, this rule does not change the fact that a member is liable for the charges and it does not preclude the provider from attempting to collect them.

n. The member shall pay a \$3 copayment for each visit to a hospital emergency room for treatment that does not meet the criteria for an emergency service as defined in paragraph 79.1(13) "k." This \$3 copayment will not apply if the visit to the emergency room results in a hospital admission.

79.1(14) Reimbursement for hospice services.

a. Medicaid hospice rates. The Medicaid hospice rates are based on the methodology used in setting Medicare rates, adjusted to disregard cost offsets attributable to Medicare coinsurance amounts, and with application of the appropriate area wage adjustments for the categories of care provided.

Hospices are reimbursed at one of four predetermined rates based on the level of care furnished to the individual for that day. Payments to a hospice for inpatient care are subject to the limitations imposed by Medicare. The levels of care into which each day of care is classified are as follows:

- (1) Routine home care.
- (2) Continuous home care.
- (3) Inpatient respite care.
- (4) General inpatient care.

b. Adjustment to hospice rates. An adjustment to hospice reimbursement is made when a recipient residing in a nursing facility elects the hospice benefit. The adjustment will be a room and board rate that is equal to the rate at which the facility is paid for reserved bed days or 95 percent of the facility's Medicaid reimbursement rate, whichever is greater. Room and board services include the performance of personal care services, including assistance in activities of daily living, socializing activities, administration of medication, maintaining the cleanliness of a resident's room and supervising and assisting in the use of durable medical equipment and prescribed therapies.

For hospice recipients entering a nursing facility, the adjustment will be effective the date of entry. For persons in nursing facilities prior to hospice election, the adjustment rate will be effective the date of election.

For individuals who have client participation amounts attributable to their cost of care, the adjustment to the hospice will be reduced by the amount of client participation as determined by the department. The hospice will be responsible for collecting the client participation amount due the hospice unless the hospice and the nursing facility jointly determine the nursing facility is to collect the client participation.

c. Payment for day of discharge. For the day of discharge from an inpatient unit, the appropriate home care rate is to be paid unless the recipient dies as an inpatient. When the recipient is discharged as deceased, the inpatient rate (general or respite) is to be paid for the discharge date.

d. Hospice cap. Overall aggregate payments made to a hospice during a hospice cap period are limited or capped. The hospice cap year begins November 1 and ends October 31 of the next year. The cap amount for each hospice is calculated by multiplying the number of beneficiaries electing hospice care from that hospice during the cap period by the base statutory amount, adjusted to reflect the percentage increase or decrease in the medical care expenditure category of the Consumer Price Index for all urban consumers published by the Bureau of Labor Statistics. Payments made to a hospice but not included in the cap include room and board payment to a nursing home. Any payment in excess of the cap must be refunded to the department by the hospice.

e. Limitation of payments for inpatient care. Payments to a hospice for inpatient care will be limited according to the number of days of inpatient care furnished to Medicaid patients. During the 12-month period beginning November 1 of each year and ending October 31, the aggregate number of inpatient days (both for general inpatient care and inpatient respite care) will not exceed 20 percent of the aggregate total number of days of hospice care provided to all Medicaid recipients during that same period. Medicaid recipients afflicted with acquired immunodeficiency syndrome (AIDS) are excluded in calculating this inpatient care limitation. This limitation is applied once each year, at the end of the hospices' "cap period" (November 1 to October 31). For purposes of this computation, if it is determined that the inpatient rate should not be paid, any days for which the hospice receives payment at a home care rate will not be counted as inpatient days. The limitation is calculated as follows:

- (1) The maximum allowable number of inpatient days will be calculated by multiplying the total number of days of Medicaid hospice care by 0.2.

(2) If the total number of days of inpatient care furnished to Medicaid hospice patients is less than or equal to the maximum, no adjustment will be necessary.

(3) If the total number of days of inpatient care exceeded the maximum allowable number, the limitation will be determined by:

1. Calculating a ratio of the maximum allowable days to the number of actual days of inpatient care, and multiplying this ratio by the total reimbursement for inpatient care (general inpatient and inpatient respite reimbursement) that was made.
2. Multiplying excess inpatient care days by the routine home care rate.
3. Adding together the amounts calculated in “1” and “2.”
4. Comparing the amount in “3” with interim payments made to the hospice for inpatient care during the “cap period.”

Any excess reimbursement shall be refunded by the hospice.

f. Location of services. Claims must identify the geographic location where the service is provided (as distinct from the location of the hospice).

79.1(15) *HCBS retrospectively limited prospective rates.* This methodology applies to reimbursement for HCBS brain injury waiver supported community living; HCBS intellectual disability waiver supported community living for 15-minute services; HCBS children’s mental health waiver family and community support services; and HCBS interim medical monitoring and treatment when provided by an HCBS-certified supported community agency under an HCBS intellectual disability waiver, brain injury waiver, or health and disability waiver.

a. Reporting requirements.

(1) Providers shall submit the completed certification form prescribed by the department. The provider shall email the report and required supplemental information to the email address specified on the form. The provider shall mail one signed copy of the certification page to Iowa Medicaid at the department’s address, no later than the due date of the required electronic submissions.

(2) The provider shall submit a financial and statistical report coinciding with the provider’s fiscal year.

(3) The provider shall submit the financial and statistical report on or before the last day of the third month following the end of the cost reporting period.

(4) A certified home health agency enrolled to deliver HCBS that is required to submit a Medicare cost report may request a 60-day extension for submitting the financial and statistical cost report. All other providers may request a 30-day extension for submitting the financial and statistical report. All requests must be submitted in writing to Iowa Medicaid by the financial and statistical report due date. No other extensions will be granted.

(5) If a provider terminates its participation in any HCBS program or service, the provider shall submit a final financial and statistical report on or before the sixtieth day following the date of termination for retrospective adjustment in accordance with subparagraph 79.1(15) “*f*”(1).

(6) Providers failing to submit a financial and statistical report that meets the requirements of this paragraph within the time frames set forth in subparagraph 79.1(15) “*a*”(3) or “*a*”(4), as applicable, will reduce payment to 76 percent of the current rate. The reduced rate will be paid for not longer than three months, after which time no further payments will be made.

(7) Providers shall submit a completed financial and statistical report in an electronic format that can be opened using the extension xls or.xlsx. The provider shall submit supplemental documentation in a generally accepted business format.

(8) Along with its financial and statistical report, the provider shall include a working trial balance that corresponds to the data contained on the financial and statistical report. Financial and statistical reports submitted without a working trial balance will be considered incomplete.

(9) The provider’s financial data within the financial and statistical report shall be based on the provider’s financial records. When the records are not based on the accrual basis of accounting, the provider shall make adjustments necessary to convert the information to an accrual basis for reporting.

(10) Providers of multiple programs or services shall submit a cost allocation schedule. The schedule must identify an allocation method for each expense account, including the statistics used in the calculation.

(11) Providers shall not report costs to any waiver service that are costs of any other program or public or private funding sources, including but not limited to the Medicaid state plan; Medicare; other state, local or federal funded programs; and private funding sources. Providers shall not report costs of HCBS waiver services as a cost of any other public or private funding source.

(12) Iowa Medicaid or its designee may review or audit financial and statistical reports as filed to determine the actual cost of services in accordance with generally accepted accounting principles or Medicare cost principles published in Centers for Medicare and Medicaid Services Publication §15-1 as amended to July 1, 2026, subject to the exceptions and limitations in the department's administrative rules and financial and statistical report instructions.

(13) Failure to maintain records to support the financial and statistical report and make them available to the department or its designee upon request may result in adjustment, payment reduction, or sanction including but not limited to termination of the provider's HCBS certification.

(14) When adjustments made to prior reports indicate noncompliance with reporting instructions or the provider has a history of inadequate documentation to support the financial and statistical report, the department may require that an external accountant experienced with cost report preparation prepare the financial and statistical report or that a certified public accountant complete a review or examination of the financial and statistical report or cost allocation methodology.

b. Home- and community-based general rate criteria.

(1) To receive reimbursement for services, a certified provider shall enter into an agreement with the department on the form specified by the department and have an approved service plan for the member.

(2) The rates a provider may charge are subject to limits established in subrule 79.1(2).

(3) Twenty percent identified cost limitation.

1. The following identified costs are not subject to the 20 percent limitation; however, the following costs are used to calculate the limitation:

- Wages, benefits, and payroll taxes.
- Direct care transportation expense—with and without member present.
- Direct care development, training, and supplies.
- Member-specific assistance.
- Member-specific equipment repair or purchase.

2. For each waiver service, the sum of reported costs not identified in numbered paragraph 79.1(15)“b”(3)“1” is limited to 20 percent of the identified costs in numbered paragraph 79.1(15)“b”(3)“1.”

(4) Mileage reimbursement for business use of personal employee vehicles will be limited to the federal Internal Revenue Service's (IRS's) published mileage rate in effect during the cost reporting period.

(5) Compensation for services of owners or immediate relatives is an allowable cost, provided the services are actually performed in a necessary function and do not exceed the maximum allowed compensation as described in numbered paragraphs 79.1(15)“b”(5)“5” and “6.”

1. “Ownership” is defined as an interest of 5 percent or more. For this purpose, the following persons are considered immediate relatives: husband, wife, natural or adoptive parent, natural or adoptive child, natural or adoptive sibling, step-parent, step-child, step-sibling, parent-in-law, child-in-law, sibling-in-law, grandparent, or grandchild. Adequate time records shall be maintained.

2. “Compensation” means the total benefit received by the owner or immediate relative for services rendered. Compensation includes all remuneration, paid currently or accrued, for managerial, administrative, professional and other services rendered during the period. Compensation shall include all items that should be reflected on IRS Form W-2, Wage and Tax Statement, including but not limited to salaries, wages, and fringe benefits; the cost of assets and services received; and deferred

compensation. Fringe benefits include but are not limited to costs of leave, employee insurance, pensions and unemployment plans. If the facility's fiscal year end does not correlate to the period of the W-2, a reconciliation between the latest-issued W-2 and current compensation shall be required to be disclosed to Iowa Medicaid or its designee. Employer portions of payroll taxes associated with amounts of compensation that exceed the maximum allowed compensation will be considered unallowable for reimbursement. Providers shall report all compensation paid to related parties, including payroll taxes, on the financial and statistical report.

3. "Reasonableness" requires that the compensation allowance be such an amount as would ordinarily be paid for comparable services by comparable providers, and depends upon the facts and circumstances of each case.

4. "Necessary" requires that the function be such that had the owner or immediate relative not rendered the services, the facility would have had to employ another person to perform the service and be pertinent to the operation and sound conduct of the institution.

5. The maximum allowed compensation for the executive director, corporate executive officer, or equivalent position, who is an owner or immediate relative, is equal to the intermediate care facility for persons with an intellectual disability (ICF/ID) maximum compensation for facilities with 60 beds or more pursuant to 441—subparagraph 82.4(11) "e"(4).

6. The maximum allowed compensation for any other owner or immediate relative is 60 percent of the amount allowed in numbered paragraph 79.1(15) "b"(5) "5."

7. The provider shall maintain records in the same manner for an owner or immediate relative compensated by the agency as are maintained for any employee of the agency, including but not limited to employment records, timekeeping, and payroll records.

8. The maximum allowed compensation for owners and immediate relatives shall be adjusted by the percentage of the average workweek devoted to business activity during the fiscal year of the financial and statistical report. The time devoted to the business shall be disclosed on the financial and statistical report. If an owner's or immediate relative's time is allocated to the facility from another entity (e.g., home office), the compensation limit shall be adjusted by the percentage of total costs of the entity allocated to the facility. In no case shall the amount of salary for one owner or immediate relative allocated to multiple facilities be more than the maximum allowed compensation for that employee had the salary been allocated to only one agency.

9. Costs applicable to services, facilities, and supplies furnished to the provider by a person or organization related to the provider by common ownership or control are a reimbursable cost when included at the cost to the related party or organization. The cost shall not exceed the price of comparable services, facilities, or supplies that could be purchased elsewhere.

- "Related" means that the agency, to a significant extent, is associated with or has control of or is controlled by the organization furnishing the services, facilities, or supplies.

- Common ownership exists when an individual or individuals possess significant ownership or equity in the facility and the institution or organization serving the provider.

- Control exists where an individual or an organization has power, directly or indirectly, to significantly influence or direct the actions or policies of an organization or institution.

- A provider may lease a facility from a related person or organization. In such case, the rent paid to the lessor by the provider is not allowable as a cost. The provider, however, would include in its cost the costs of ownership of the facility. This includes depreciation, interest on the mortgage, real estate taxes, and other expenses attributable to the leased facility.

- An exception is provided to the general rule applicable to related organizations. The exception applies if the provider demonstrates by convincing evidence that the criteria in numbered paragraph 79.1(15) "b"(5) "10" have been met.

10. The agency must demonstrate the following with convincing evidence. Where all of the conditions below are met, the charges by the supplier to the provider for such services, facilities, or supplies are allowable as costs.

- The supplying organization is a bona fide separate organization;

- A substantial part of its business activity of the type carried on with the facility is transacted with others and there is an open competitive market for the type of services, facilities, or supplies furnished by the organization;

- The services, facilities, or supplies are those which commonly are obtained by similar institutions from other organizations and are not a basic element of patient care ordinarily furnished directly to patients by the institutions; and

- The charge to the agency is in line with the charge for services, facilities, or supplies in the open market and no more than the charge made under comparable circumstances to others by the organization for the services, facilities, or supplies.

c. Prospective rates for new providers.

(1) “New providers” means providers who have not submitted an annual report including at least six months of actual, historical costs of operations for any service as listed in subrule 79.1(15).

(2) New providers will be paid prospective rates based on projected reasonable and proper costs of operation for a 12-month period.

(3) Projected costs of any new service, as listed in subrule 79.1(15), shall be submitted on the applicable form prescribed by the department.

(4) Prospective rates will be subject to retrospective adjustment as provided in paragraph 79.1(15)“f.”

(5) After a provider has submitted an annual report including at least six months of actual, historical costs, prospective rates will be determined as provided in paragraph 79.1(15)“d.”

d. Prospective rates for established providers.

(1) “Established providers” means providers who have submitted an annual report including six months of actual, historical costs of operation.

(2) The prospective rate will be adjusted annually, effective the first day of the third month after the month during which the annual financial and statistical report is submitted to the department.

(3) The provider’s prospective rate will be the lower of:

1. The provider’s reasonable and proper actual cost-based rate as calculated by the provider’s most recent financial and statistical report and adjusted by the consumer price index for all urban consumers for the preceding 12-month period ending as of the provider’s fiscal year end,

2. In the first year of reporting six months of actual, historical costs of operation, or a year in which the provider’s base rate is recalculated, the base rate is equal to the amount calculated in numbered paragraph 79.1(15)“d”(3)“1,”

3. In a year in which the provider’s base rate is not recalculated, the prior period base rate adjusted by the consumer price index for all urban consumers for the preceding 12-month period ending as of the provider’s fiscal year end, or

4. The upper rate limit pursuant to subrule 79.1(2).

(4) Recalculation of base rates (rebasings).

1. For providers of HCBS brain injury waiver supported community living services; HCBS children’s mental health waiver family and community support services; and interim medical monitoring and treatment services when provided by an HCBS-certified supported community living services agency, the base rates will be recalculated based on the reasonable and proper actual costs of operation as calculated by the fiscal year 2022 financial and statistical report.

2. For providers of HCBS brain injury waiver supported community living services; HCBS children’s mental health waiver family and community support services; interim medical monitoring and treatment services when provided by an HCBS-certified supported community living services agency; and 15-minute HCBS intellectual disability waiver supported community living services, the base rates will be recalculated based on the reasonable and proper costs of operation for the provider’s fiscal year ending on or after January 1, 2024.

3. Subsequent to the recalculation of base rates in numbered paragraph 79.1(15)“d”(4)“2,” a provider’s base rate will be recalculated no less than every three years.

(5) Prospective rates will be subject to retrospective adjustment as provided in paragraph 79.1(15) “f.”

e. Reserved.

f. Retrospective adjustments.

(1) For fee for service, retrospective adjustments will be made based on reconciliation of provider’s reasonable and proper actual service costs with the revenues received for 15-minute HCBS intellectual disability waiver supported community living services; HCBS brain injury waiver supported community living services; HCBS children’s mental health waiver family and community support services; and interim medical monitoring and treatment services when provided by an HCBS-certified supported community living services agency under an HCBS intellectual disability waiver, brain injury waiver, and health and disability waiver, as reported on the applicable department form, subject to the upper rate limit allowed in subrule 79.1(2).

(2) For services provided on or after July 1, 2016, revenues exceeding adjusted actual costs by more than 5.5 percent for fee for service will be remitted to the department. Payment will be due upon notice of the new rates and retrospective rate adjustment.

(3) If a provider does not remit the amount of the overpayment identified in subparagraph 79.1(15) “f”(2) within 30 days after notice, the department will deduct the amount owed from future payments.

79.1(16) Outpatient reimbursement for hospitals.

a. Definitions.

“Allowable costs” means the costs defined as allowable in 42 CFR, Chapter IV, Part 413, as amended to July 1, 2026, except for the purposes of calculating direct medical education costs, where only the reported costs of the interns and residents are allowed. Further, costs are allowable only to the extent that they relate to patient care; are reasonable, ordinary, and necessary; and are not in excess of what a prudent and cost-conscious buyer would pay for the given service or item.

“Ambulatory payment classification” or “APC” means an outpatient service or group of services for which a single rate is set. The services or groups of services are determined according to the typical clinical characteristics, the resource use, and the costs associated with the service or services.

“Ambulatory payment classification relative weight” or “APC relative weight” means the relative value assigned to each APC.

“Ancillary service” means a supplemental service that supports the diagnosis or treatment of the patient’s condition. Examples include diagnostic testing or screening services and rehabilitative services such as physical or occupational therapy.

“APC service” means a service that is priced and paid using the APC system.

“Base year cost report,” for rates effective January 1, 2024, means the hospital’s cost report with fiscal year end on or after January 1, 2022, and before January 1, 2023. Cost reports will be reviewed using Medicare’s cost reporting and cost reimbursement principles for those cost reporting periods.

“Blended base APC rate” means the hospital-specific base APC rate, plus the statewide base APC rate, divided by two. The costs of hospitals receiving reimbursement as critical access hospitals during any of the period included in the base year cost report will not be used in determining the statewide base APC rate.

“Cost outlier” means services provided during a single visit that have an extraordinarily high cost as established in paragraph 79.1(16) “g” and are therefore eligible for additional payments above and beyond the base APC payment.

“Current procedural terminology—fourth edition (CPT-4)” or “CPT” is the systematic listing and coding of procedures and services provided by physicians or other related health care providers. The CPT-4 coding is maintained by the American Medical Association and is updated yearly. For the purposes of this rule, “CPT” means the coding as amended to July 1, 2026.

“Diagnostic service” means an examination or procedure performed to obtain information regarding the medical condition of an outpatient.

“Direct medical education costs” means costs directly associated with the medical education of interns and residents or other medical education programs, such as a nursing education program or allied health programs, conducted in an outpatient setting, that qualify for payment as medical education costs under the Medicare program. The amount of direct medical education costs is determined from the hospital base year cost reports in determining the direct medical education rate.

“Direct medical education rate” means a rate calculated for a hospital reporting medical education costs on the Medicare cost report (CMS 2552). The rate is calculated using the following formula: Direct medical education costs are multiplied by the factor used to limit aggregate expenditures to available funding and then divided by the sum of outpatient relative discounted APC weights.

“Discount factor” means the percentage discount applied to additional APCs when more than one APC is provided during the same visit (including the same APC provided more than once). Not all APCs are subject to a discount factor.

“GME/DSH fund apportionment claim set” means the hospital’s applicable Medicaid base year cost report. The claim set is updated every three years in July and is modeled using recalibrated weights pursuant to paragraph 79.1(5) “k.”

“Graduate medical education and disproportionate share fund” or *“GME/DSH fund”* means a reimbursement fund developed as an adjunct reimbursement methodology to directly reimburse qualifying hospitals for the direct costs of interns and residents associated with the operation of graduate medical education programs for outpatient services.

“Healthcare common procedures coding system” or *“HCPCS”* means the national uniform coding method that is maintained by the Centers for Medicare and Medicaid Services (CMS) and that incorporates the CPT and the three HCPCS unique coding levels I, II, and III.

“Hospital-based clinic” means a clinic that is owned by the hospital, operated by the hospital under its hospital license, and on the premises of the hospital.

“Medicaid claim set” means the hospital’s applicable Medicaid claims for the period of January 1, 2019, through December 31, 2020, and paid through March 31, 2020.

“Modifier” means a two-character code that is added to the procedure code to indicate the type of service performed. The modifier allows the reporting hospital to indicate that a performed service or procedure has been altered by some specific circumstance. The modifier may affect payment or may be used for information only.

“Multiple significant procedure discounting” means a reduction of the standard payment amount for an APC to recognize that the marginal cost of providing a second APC service to a patient during a single visit is less than the cost of providing that service by itself.

“Observation services” means a set of clinically appropriate services, such as ongoing short-term treatment, assessment, and reassessment, that is provided before a decision can be made regarding whether a patient needs further treatment as a hospital inpatient or is able to be discharged from the hospital.

“Outpatient hospital services” means preventive, diagnostic, therapeutic, observation, rehabilitation, or palliative services provided to an outpatient by or under the direction of a physician, dentist, or other practitioner by an institution that:

1. Is licensed or formally approved as a hospital by the officially designated authority in the state where the institution is located; and
2. Meets the requirements for participation in Medicare as a hospital.

“Outpatient prospective payment system” or *“OPPS”* means the payment methodology for hospital outpatient services established by this subrule and based on Medicare’s outpatient prospective payment system mandated by the Balanced Budget Refinement Act of 1999 as amended to July 1, 2026, and the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 as amended to July 1, 2026.

“Outpatient visit” means those hospital-based outpatient services that are billed on a single claim form.

“Packaged service” means a service that is secondary to other services but is considered an integral part of another service.

“Pass-through” means certain drugs, devices, and biologicals for which providers are entitled to payment separate from any APC.

“Rebasing” means the redetermination of the blended base APC rate using more recent Medicaid cost report data.

“Significant procedure” means the procedure, therapy, or service provided to a patient that constitutes the primary reason for the visit and dominates the time and resources expended during the visit.

“Status indicator” or *“SI”* means a payment indicator that identifies whether a service represented by a CPT or HCPCS code is payable under the OPPS APC or another payment system. Only one status indicator is assigned to each CPT or HCPCS code.

b. Outpatient hospital services. Medicaid adopts the Medicare categories of hospitals and services subject to and excluded from the hospital outpatient prospective payment system (OPPS) at 42 CFR 419.20 through 419.22 as amended to July 1, 2026, except as indicated in this subrule.

(1) A teaching hospital that has approval from the Centers for Medicare and Medicaid Services (CMS) to receive reasonable cost reimbursement for physician services under 42 CFR 415.160 through 415.162 as amended to July 1, 2026, is eligible for combined billing status if the hospital has filed the approval notice with Iowa Medicaid. If a teaching hospital elects to receive reasonable cost payment for physician direct medical and surgical services furnished to Medicaid members, those services and the supervision of interns and residents furnishing the care to members are covered as hospital services and are combined with the bill for hospital service. Cost settlement for the reasonable costs related to physician direct medical and surgical services will be made after receipt of the hospital's financial and statistical report.

(2) A hospital-based ambulance service must be an enrolled Medicaid ambulance provider and must bill separately for ambulance services. EXCEPTION: If the member's condition results in an inpatient admission to the hospital, the reimbursement for ambulance services is included in the hospital's DRG reimbursement rate for the inpatient services.

c. Payment for outpatient hospital services.

(1) Outpatient hospital services will be reimbursed according to the first of the following methodologies that applies to the service:

1. Any specific rate or methodology established by rule for the particular service.
2. The OPPS APC rates established pursuant to this subrule.
3. Fee schedule rates established pursuant to paragraph 79.1(1)“c.”

(2) Except as provided in paragraph 79.1(16)“h,” outpatient hospital services that have been assigned to an APC with an assigned weight will be reimbursed based on the APC to which the services provided are assigned. The department adopts and incorporates by reference the OPPS APCs and relative weights effective January 1, 2008, published on November 27, 2007, as final by the Centers for Medicare and Medicaid Services in the Federal Register at Volume 72, No. 227, page 66579. Relative weights and APCs will be updated pursuant to paragraph 79.1(16)“j.”

(3) The APC payment is calculated as follows:

1. The applicable APC relative weight is multiplied by the blended base APC rate determined according to paragraph 79.1(16)“e.”
2. The resulting APC payment is multiplied by a discount factor and by units of service when applicable.
3. For a procedure started but discontinued before completion, the department will pay 50 percent of the APC for the service.

(4) The OPPS APC payment status indicators show whether a service represented by a CPT or HCPCS code is payable under an OPPS APC or under another payment system and whether particular OPPS policies apply to the code. The following table lists the status indicators and definitions for both services that are paid under an OPPS APC and services that are not paid under an OPPS APC.

Indicator	Item, Code, or Service	OPPS Payment Status
A	Services furnished to a hospital outpatient that are paid by Medicare under a fee schedule or payment system other than OPPS, such as: ● Ambulance services. ● Separately payable clinical diagnostic laboratory services. ● Diagnostic mammography. ● Screening mammography. ● Separately payable nonimplantable prosthetic and orthotic devices. ● Physical, occupational, and speech therapy.	For services covered by Iowa Medicaid as an outpatient hospital service, the service is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1) "c." For services not covered by Iowa Medicaid as an outpatient hospital service, the service is not paid under OPPS APC but may be paid by Iowa Medicaid under the specific rate or methodology established by other rules (other than outpatient hospital).
B	Codes that are not paid by Medicare on an outpatient hospital basis	Not paid under OPPS APC. ● May be paid when submitted on a different bill type other than outpatient hospital (13x). ● An alternate code that is payable when submitted on an outpatient hospital bill type (13x) may be available.
C	Inpatient procedures	If covered by Iowa Medicaid as an outpatient hospital service, the service is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1) "c." If not covered by Iowa Medicaid as an outpatient hospital service, the service is not paid under OPPS APC. Admit the patient and bill as inpatient care.
D	Discontinued codes	Not paid under OPPS APC or any other Medicaid payment system.
E1	Items, codes, and services: ● That are not covered by Medicare based on statutory exclusion and may or may not be covered by Iowa Medicaid; or ● That are not covered by Medicare for reasons other than statutory exclusion and may or may not be covered by Iowa Medicaid.	If covered by Iowa Medicaid, the item, code, or service is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1) "c." If not covered by Iowa Medicaid, the item, code, or service is not paid under OPPS APC or any other Medicaid payment system.
E2	Items, codes, and services: ● That are not recognized by Medicare but for which an alternate code for the same item or service may be available under Iowa Medicaid; or ● For which separate payment is not provided by Medicare but may be provided by Iowa Medicaid.	If covered by Iowa Medicaid, the item, code, or service is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1) "c." If not covered by Iowa Medicaid, the item, code, or service is not paid under OPPS APC or any other Medicaid payment system.
F	Certified registered nurse anesthetist services Corneal tissue acquisition Hepatitis B vaccines	If covered by Iowa Medicaid, the item or service is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1) "c." If not covered by Iowa Medicaid, the item or service is not paid under OPPS APC or any other Medicaid payment system.
G	Pass-through drugs and biologicals	If covered by Iowa Medicaid, the item is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1) "c." If not covered by Iowa Medicaid, the item is not paid under OPPS APC or any other Medicaid payment system.
H	Pass-through device categories	If covered by Iowa Medicaid, the device is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1) "c."

Indicator	Item, Code, or Service	OPPS Payment Status
		If not covered by Iowa Medicaid, the device is not paid under OPPS APC or any other Medicaid payment system.
J1	Hospital Part B services paid through a comprehensive APC	If covered by Iowa Medicaid, the service is paid under OPPS APC. All covered Part B services on the claim, except services with OPPS SI=F, G, H, L, and U; ambulance services; diagnostic and screening mammography; and all preventive services. If not covered by Iowa Medicaid, the device is not paid under OPPS APC or any other Medicaid payment system.
J2	Hospital Part B services that may be paid through a comprehensive APC	If covered by Iowa Medicaid, the item is: ● Paid under OPPS APC with a separate APC payment when both an APC and an APC weight are established. ● Paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)“c” when either no APC or APC weight is established. ● In other circumstances, payment is made through a separate APC payment. If not covered by Iowa Medicaid, the device is not paid under OPPS APC or any other Medicaid payment system.
K	Non-pass-through drugs and biologicals Therapeutic radiopharmaceuticals	If covered by Iowa Medicaid, the item is: ● Paid under OPPS APC with a separate APC payment when both an APC and an APC weight are established. ● Paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)“c” when either no APC or APC weight is established. If not covered by Iowa Medicaid, the item is not paid under OPPS APC or any other Medicaid payment system.
L	Influenza vaccine Pneumococcal pneumonia vaccine	If covered by Iowa Medicaid, the vaccine is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)“c.” If not covered by Iowa Medicaid, the vaccine is not paid under OPPS APC or any other Medicaid payment system.
M	Items and services not billable to the Medicare fiscal intermediary	If covered by Iowa Medicaid, the item or service is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)“c.” If not covered by Iowa Medicaid, the item or service is not paid under OPPS APC or any other Medicaid payment system.
N	Packaged services not subject to separate payment under Medicare OPPS payment criteria	Paid under OPPS APC. Payment, including outliers, is included with payment for other services; therefore, no separate payment is made.
P	Partial hospitalization	Not a covered service under Iowa Medicaid.
Q1	STV-packaged codes	Paid under OPPS APC. ● Packaged APC payment if billed on the same date of service as HCPCS code assigned status indicator “S,” “T,” or “V.” ● In all other circumstances, payment is made through a separate APC payment.
Q2	T-packaged codes	Paid under OPPS APC.

Indicator	Item, Code, or Service	OPPS Payment Status
		● Packaged APC payment if billed on the same date of service as HCPCS code assigned status indicator “T.” ● In all other circumstances, payment is made through a separate APC payment.
Q3	Codes that may be paid through a composite APC	Paid under OPPS APC. ● Composite APC payment based on OPPS composite-specific payment criteria. Payment is packaged into a single payment for specific combinations of services. ● In other circumstances, payment is made through a separate APC payment or packaged into payment for other services.
Q4	Conditionally packaged laboratory tests	Paid under OPPS APC or Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)“c.” ● Packaged APC payment if billed on the same claim as HCPCS code assigned published status indicator “J1,” “J2,” “S,” “T,” “V,” “Q1,” “Q2,” or “Q3.” ● In other circumstances, laboratory tests should have a status indicator of “A” and payment is made under the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)“c.”
R	Blood and blood products	If covered by Iowa Medicaid, the item is paid under OPPS APC with separate APC payment. If not covered by Iowa Medicaid, the item is not paid under OPPS APC or any other Medicaid payment system.
S	Significant procedure, not discounted when multiple	If covered by Iowa Medicaid, the procedure is paid under OPPS APC with separate APC payment. If not covered by Iowa Medicaid, the procedure is not paid under OPPS APC or any other Medicaid payment system.
T	Significant procedure, multiple reduction applies	If covered by Iowa Medicaid, the procedure is paid under OPPS APC with separate APC payment subject to multiple reduction. If not covered by Iowa Medicaid, the procedure is not paid under OPPS APC or any other Medicaid payment system.
U	Brachytherapy sources	If covered by Iowa Medicaid, the procedure is paid under OPPS APC with separate APC payment. If not covered by Iowa Medicaid, the procedure is not paid under OPPS APC or any other Medicaid payment system.
V	Clinic or emergency department visit	If covered by Iowa Medicaid, the service is paid under OPPS APC with separate APC payment, subject to limits on nonemergency services provided in an emergency room pursuant to 79.1(16)“r.” If not covered by Iowa Medicaid, the service is not paid under OPPS APC or any other Medicaid payment system.
X	Nonimplantable durable medical equipment	For items covered by Iowa Medicaid as an outpatient hospital service, the item is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)“c.” For items not covered by Iowa Medicaid as an outpatient hospital service, the item is not paid as an outpatient hospital service, but may be paid by

Indicator	Item, Code, or Service	OPPS Payment Status
		Iowa Medicaid under the specific rate or methodology established by other rules (other than outpatient hospital).

d. Reserved.

e. *Calculation of the hospital-specific base APC rates.*

(1) Using the hospital's base year cost report, hospital-specific outpatient cost-to-charge ratios are calculated for each ancillary and outpatient cost center of the Medicare cost report, Form CMS 2552.

(2) The cost-to-charge ratios are applied to each line-item charge reported on claims from the Medicaid claim set to calculate the Medicaid cost per service. The hospital's total outpatient Medicaid cost is the sum of the Medicaid cost per service for all line items.

(3) The following items are subtracted from the hospital's total outpatient Medicaid costs:

1. The total calculated Medicaid direct medical education cost for interns and residents based on the hospital's base year cost report.

2. The total calculated Medicaid cost for services listed at 441—paragraphs 78.31(1)“g” through “n.”

3. The total calculated Medicaid cost for ambulance services.

4. The total calculated Medicaid cost for services paid based on the Iowa Medicaid fee schedule.

(4) The remaining amount is multiplied by a factor to limit aggregate expenditures to available funding and then divided by the hospital-specific sum of relative discounted APC weights in the Medicaid claim set.

(5) Hospital-specific base APC rates are not computed for hospitals receiving reimbursement as critical access hospitals during any of the period included in the base year cost report.

f. *Calculation of statewide base APC rate.*

(1) The statewide average base APC rate is calculated by summing the outpatient Medicaid cost for all hospitals and subtracting the following:

1. The total calculated Medicaid direct medical education cost for interns and residents for all hospitals.

2. The total calculated Medicaid cost for services listed at 441—paragraphs 78.31(1)“g” through “n,” for all hospitals.

3. The total calculated Medicaid cost for ambulance services for all hospitals.

4. The total calculated Medicaid cost for services paid based on the Iowa Medicaid fee schedule for all hospitals.

(2) The resulting amount is multiplied by a factor to maintain expenditures within the amount appropriated to the department for this purpose and then divided by the sum of relative discounted APC weights in the Medicaid claim set.

(3) Data for hospitals receiving reimbursement as critical access hospitals during any of the period included in the base year cost report is not used in calculating the statewide average base APC rate.

g. *Cost outlier payment policy.* Additional payment is made for services provided during a single visit that exceed the following Medicaid criteria of cost outliers for each APC. Outlier payments are determined on an APC-by-APC basis.

(1) An APC qualifies as a cost outlier when the cost of the service exceeds both the multiple threshold and the fixed-dollar threshold.

(2) The multiple threshold is met when the cost of furnishing an APC service exceeds 1.75 times the APC payment amount.

(3) The fixed-dollar threshold is met when the cost of furnishing an APC service exceeds the APC payment amount plus \$2,000.

(4) If both the multiple threshold and the fixed-dollar threshold are met, the outlier payment is calculated as 50 percent of the amount by which the hospital's cost of furnishing the APC service or procedure exceeds the multiple threshold.

(5) The cost of furnishing the APC service or procedure is calculated using a single overall hospital-specific cost-to-charge ratio determined from the base year cost report. Costs appearing on a claim that are attributable to packaged APC services for which no separate payment is made are allocated to all nonpackaged APC services that appear on that claim. The amount allocated to each nonpackaged APC service is based on the proportion the APC payment rate for that APC service bears to the total APC rates for all nonpackaged APC services on the claim.

h. Payment to critical access hospitals. Initial, interim payments to critical access hospitals as defined in paragraph 79.1(5) "a" will be the hospital's line-item charge multiplied by the hospital's Medicaid outpatient cost-to-charge ratio. These interim payments are subject to annual retrospective adjustment equal to the difference between the reasonable costs of covered services provided to eligible fee-for-service Medicaid members (excluding members in managed care) and the Medicaid reimbursement received. The department will determine the reasonable costs of services based on the hospital's annual cost reports and Medicare cost principles. When the interim amounts paid exceed reasonable costs, the department will recover the difference.

(1) After any retrospective adjustment, the department will update the cost-to-charge ratio to reflect as accurately as is possible the reasonable costs of providing the covered service to eligible fee-for-service Medicaid members for the coming year. The department will base these changes on the most recent utilization as submitted to the Iowa Medicaid and Medicare cost principles. Providers may be eligible for an "add-on" to the cost-to-charge ratio based on eligibility to participate in the annual Critical Access Hospital Cost Adjustment Factor Pool.

(2) Once a hospital begins receiving reimbursement as a critical access hospital, the cost-to-charge ratio is not subject to rebasing as provided in paragraph 79.1(16) "j."

i. Cost-reporting requirements. Hospitals shall prepare annual cost reports in accordance with generally accepted accounting principles as defined by the American Institute of Certified Public Accountants and in accordance with Medicare Provider Reimbursement Manual, CMS Publication 15 as amended to July 1, 2026, subject to the exceptions and limitations provided in this rule.

(1) Using electronic media, each hospital shall submit the following:

1. The hospital's Medicare cost report (Form CMS 2552, Hospitals and Healthcare Complex Cost Report);

2. Either the Critical Access Hospital Supplemental Cost Report or the Hospital Supplemental Cost Report; and

3. A copy of the revenue code crosswalk used to prepare the Medicare cost report.

(2) The cost reports and supporting documentation shall be sent to Iowa Medicaid at the department's address.

(3) The cost reports shall be submitted on or before the last day of the fifth calendar month following the close of the period covered by the report. For fiscal periods ending on a day other than the last day of the month, cost reports are due 150 days after the last day of the cost-reporting period. Extensions of the due date for filing a cost report granted by the Medicare fiscal intermediary shall be accepted by Iowa Medicaid.

j. Rebasing.

(1) Effective January 1, 2009, and annually thereafter, the department will update the OPPS APC relative weights using the most current calendar update as published by the Centers for Medicare and Medicaid Services.

(2) Effective January 1, 2009, and every three years thereafter, blended base APC rates will be rebased. Cost reports used in rebasing will be the hospital fiscal year-end Form CMS 2552, Hospital and Healthcare Complex Cost Report, as submitted to Medicare in accordance with Medicare cost report submission timelines for the hospital fiscal year ending during the preceding calendar year. If a hospital does not provide this cost report, including the Medicaid cost report and revenue code

crosswalk, to Iowa Medicaid by May 31 of a year in which rebasing occurs, the most recent submitted cost report will be used.

(3) Effective January 1, 2009, and every three years thereafter, case-mix indices will be recalculated using valid claims most nearly matching each hospital's fiscal year end.

(4) The graduate medical education and disproportionate share fund will be updated as provided in subparagraph 79.1(16)"v"(3).

k. Payment to out-of-state hospitals. Out-of-state hospitals providing care to members of Iowa's Medicaid program will be reimbursed in the same manner as Iowa hospitals, except as provided in subparagraphs 79.1(16)"k"(1) and "k"(2).

(1) For out-of-state hospitals that submit a cost report no later than May 31 in the most recent rebasing year, APC payment amounts will be based on the blended base APC rate using hospital-specific, Iowa-only Medicaid data. For other out-of-state hospitals, APC payment amounts will be based on the Iowa statewide base APC rate.

(2) Out-of-state hospitals do not qualify for direct medical education payments pursuant to paragraph 79.1(16)"v."

l. Preadmission, preauthorization or inappropriate services. Inpatient or outpatient services that require preadmission or preprocedure approval by Iowa Medicaid are updated yearly and are available from the department.

(1) The hospital shall provide the Iowa Medicaid authorization number on the claim form to receive payment. Claims for services requiring preadmission or preprocedure approval that are submitted without this authorization number will be denied.

(2) To safeguard against other inappropriate practices, the department will monitor admission practices and quality of care. If an abuse of the prospective payment system is identified, payments for abusive practices may be reduced or denied. In reducing or denying payment, Medicaid adopts the Medicare regulations.

m. Health care access assessment inflation factor. Effective with the implementation of the health care access assessment paid, pursuant to 441—Chapter 36, a health care access assessment inflation factor will be applied to the Medicaid blended base APC rate as otherwise calculated pursuant to this subrule for all "participating hospitals" as defined in 441—subrule 36.5(1).

(1) Calculation of inflation factor. The health care access assessment inflation factor for participating hospitals will be calculated by dividing the amount allowed under the Medicare outpatient upper payment limit for the fiscal year beginning July 1, 2010, by the sum of the projected expenditures for participating hospitals for the fiscal year beginning July 1, 2010, as determined by the fiscal management division of the department, and the amount allowed under the Medicare outpatient upper payment limit.

(2) Implementation date. The health care access assessment inflation factor will not be implemented until federal financial participation to match money collected from the health care access assessment, pursuant to 441—Chapter 36, has been approved by the federal Centers for Medicare and Medicaid Services.

(3) End date. Application of the health care access assessment inflation factor will terminate if the health care access assessment is terminated. If federal match money is unavailable for a retroactive period or the authority to collect the assessment is rescinded for a retroactive period, the department will:

1. Recalculate Medicaid rates in effect during that period without the application of the health care access assessment inflation factor;
2. Recompute Medicaid payments due based on the recalculated Medicaid rates;
3. Recoup any previous overpayments; and
4. Determine for each hospital the amount of health care access assessment collected during that period and refund that amount to the facility.

n. Determination of inpatient admission. A person is considered to be an inpatient when a formal inpatient admission occurs, when a physician intends to admit a person as an inpatient, or when

a physician determines that a person being observed as an outpatient in an observation or holding bed should be admitted to the hospital as an inpatient. In cases involving outpatient observation status, the determinant of patient status is not the length of time the patient was being observed, rather whether the observation period was medically necessary to determine whether a patient should be admitted to the hospital as an inpatient. Outpatient observation lasting greater than a 24-hour period will be subject to review by Iowa Medicaid to determine the medical necessity of each case. For those outpatient observation cases where medical necessity is not established, reimbursement will be denied for the services found to be unnecessary for the provision of that care, such as the use of the observation room.

o. Inpatient admission after outpatient services. If a patient is admitted as an inpatient within three days of the day in which outpatient services were rendered, all outpatient services related to the principal diagnosis are considered inpatient services for billing purposes. The day of formal admission as an inpatient is considered as the first day of hospital inpatient services. EXCEPTION: This requirement does not apply to critical access hospitals.

p. Reserved.

q. Determination of payment amounts for mental health noninpatient (NIP) services. Mental health NIP services are limited as set forth at 441—subparagraph 78.31(4)“d”(7) and are reimbursed on a fee schedule basis.

r. Services delivered in the emergency room. Payment to a hospital for assessment of any Medicaid member in an emergency room will be made pursuant to a fee schedule. Payment for treatment of a Medicaid member in an emergency room will be made as follows:

(1) If the emergency room visit results in an inpatient hospital admission, the treatment provided in the emergency room is paid for as part of the payment for the inpatient services provided.

(2) If the emergency room visit does not result in an inpatient hospital admission but involves emergency services as defined in paragraph 79.1(13)“k,” payment for treatment provided in the emergency room will be made at the full APC payment for the treatment provided.

(3) If the emergency room visit does not result in an inpatient hospital admission and does not involve emergency services as defined in paragraph 79.1(13)“k,” payment for treatment provided in the emergency room depends on whether the member had a referral to the emergency room.

1. For members who were referred to the emergency room by appropriate medical personnel, payment for treatment provided in the emergency room will be made at 75 percent of the APC payment for the treatment provided.

2. For members who were not referred to the emergency room by appropriate medical personnel, payment for treatment provided in the emergency room will be made at 50 percent of the APC payment for the treatment provided.

s. Limit on payments. Payments under the APC methodology, as well as other payments for outpatient services, are subject to upper limit rules set forth in 42 CFR 447.321 and 447.325, both as amended to July 1, 2026. Requirements under these sections state that, in general, Medicaid may not make payments to providers that would exceed the amount that would be payable to providers under comparable circumstances under Medicare.

t. Reserved.

u. Iowa Medicaid review. The department will review a yearly random sample of hospital outpatient service cases performed for Medicaid members and identified on claims data from all Iowa and bordering state hospitals.

v. Graduate medical education and disproportionate share fund. Payment will be made to hospitals qualifying for direct medical education directly from the graduate medical education and disproportionate share fund. The requirements to receive payments from the fund, the amount allocated to the fund and the methodology used to determine the distribution amounts from the fund are as follows:

(1) Qualifying for direct medical education. Iowa hospitals qualify for direct medical education payments if direct medical education costs that qualify for payment as medical education costs under

the Medicare program are contained in the hospital's base year cost report and in the most recent cost report submitted before the start of the state fiscal year for which payments are being made. Out-of-state hospitals do not qualify for direct medical education payments.

(2) Allocation to fund for direct medical education. The total annual state fiscal year funding that is allocated to the graduate medical education and disproportionate share fund for direct medical education related to outpatient services is \$2,766,718.25. If a hospital fails to qualify for direct medical education payments from the fund because the hospital does not report direct medical education costs that qualify for payment as medical education costs under the Medicare program in the most recent cost report submitted before the start of the state fiscal year for which payments are being made, the amount of money that would have been paid to that hospital will be removed from the fund.

(3) Distribution to qualifying hospitals for direct medical education. Distribution of the amount in the fund for direct medical education will be on a monthly basis. To determine the amount to be distributed to each qualifying hospital for direct medical education, the following formula is used:

1. Multiply the sum of updated OPPS relative discounted APC weights, pursuant to paragraph 79.1(16) "j," for the GME/DSH fund apportionment claim set for each hospital reporting direct medical education costs that qualify for payment as medical education costs under the Medicare program in the hospital's base year cost report by each hospital's direct medical education rate to obtain a dollar value.

2. Sum the dollar values for each hospital, then divide each hospital's dollar value by the total dollar value, resulting in a percentage.

3. Multiply each hospital's percentage by the amount allocated for direct medical education to determine the payment to each hospital.

79.1(17) *Reimbursement for home- and community-based services home and vehicle modification and equipment.* Payment is made for home and vehicle modifications, assistive devices, specialized medical equipment, and environmental modifications and adaptive devices at the amount authorized by the department through a quotation, contract, or invoice submitted by the provider.

- a. The case manager shall submit the service plan and the contract, invoice or quotations from the providers to Iowa Medicaid for prior approval before the modification is initiated or the equipment is purchased. Payment will not be approved for duplicate items.

- b. Whenever possible, three itemized bids for the modification or quotations for equipment purchase shall be presented for review. The amount payable will be based on the least expensive item that meets the member's medical needs.

- c. Payment for most items will be based on a fee schedule and will conform to the limitations set forth in subrule 79.1(12).

- (1) For services and items that are furnished under Part B of Medicare, the fee will be the lowest charge allowed under Medicare.

- (2) For services and items that are furnished only under Medicaid, the fee will be the lowest charge determined by the department according to the Medicare reimbursement method described in Section 1834(a) of the Social Security Act (42 U.S.C. 1395m as amended to July 1, 2026), Payment for Durable Medical Equipment.

- (3) Payment for supplies with no established Medicare fee will be at the average wholesale price for the item less 10 percent.

- (4) Payment for items with no Medicare fee, Medicaid fee, or average wholesale price will be made at the manufacturer's suggested retail price less 15 percent.

- (5) Payment for items with no Medicare fee, Medicaid fee, average wholesale price, or manufacturer's suggested retail price will be made at the dealer's cost plus 10 percent. The actual invoice for the item from the manufacturer must be submitted with the claim. Catalog pages or printouts supplied by the provider are not considered invoices.

(6) For selected medical services, supplies, and equipment, including equipment servicing, that generally do not vary significantly in quality from one provider to another, the payment will be the lowest price for which such devices are widely and consistently available in a locality.

(7) Payment for used equipment will not exceed 80 percent of the purchase allowance.

(8) No allowance will be made for delivery, freight, postage, or other provider operating expenses for durable medical equipment, prosthetic devices, or sickroom supplies.

79.1(18) *Pharmaceutical case management (PCM) services reimbursement.* Pharmacist and PCM team members will be equally reimbursed for participation in each of the four services described in rule 441—78.47(249A). The following table contains the amount each team member will be reimbursed for the services provided and the maximum number of payments for each type of assessment. Payment for services beyond the maximum number of payments will be considered on an individual basis after peer review of submitted documentation of medical necessity.

<u>Service</u>	<u>Payment amount</u>	<u>Number of payments</u>
Initial assessment	\$75	One per patient
New problem assessment	\$40	Two per patient per 12 months
Problem follow-up assessment	\$40	Four per patient per 12 months
Preventive follow-up assessment	\$25	One per patient per 6 months

79.1(19) *Reimbursement for translation and interpretation services.* Reimbursement for translation and interpretation services will be made to providers based on the reimbursement methodology for the provider category as defined in subrule 79.1(2).

a. For those providers whose basis of reimbursement is cost-related, translation and interpretation services will be considered an allowable cost.

b. For those providers whose basis of reimbursement is a fee schedule, a fee will be established for translation and interpretation services, which will be treated as a reimbursable service. In order for translation or interpretation to be covered, it must be provided by separate employees or contractors solely performing translation or interpretation activities.

79.1(20) *Dentists.* The dental fee schedule is based on the definitions of dental and surgical procedures given in the Code on Dental Procedures and Nomenclature (CDT) published by the American Dental Association as amended to July 1, 2026.

79.1(21) *Rehabilitation agencies.* Subject to the Medicaid upper limit in subrule 79.1(2), payments to rehabilitation agencies will be made as provided in the areawide fee schedule established for Medicare by the CMS as amended to July 1, 2026. The Medicare fee schedule is based on the definitions of procedures from the physicians' Current Procedural Terminology (CPT) published by the American Medical Association as amended to July 1, 2026. CMS adjusts the fee schedules annually to reflect changes in the consumer price index for all urban customers.

79.1(22) *Medicare crossover claims.* Subject to approval of a state plan amendment by CMS, payment for Medicare crossover claims will be made as follows.

a. Definitions. For purposes of this subrule:

“*Coinsurance*” means a percentage of costs of a covered health care service that has to be paid.

“*Copayment*” means a fixed amount a member pays for a covered health care service.

“*Deductible*” means the amount paid for covered health care services before the insurance plan will effect payment.

“*Medicaid-allowed amount*” means the Medicaid reimbursement for the service(s) rendered (including any portion to be paid by the Medicaid beneficiary as copayment or spenddown), as determined under state and federal law and policies.

“*Medicare-allowed amount*” means the total reimbursement allowed by Medicare for the service(s) rendered, for a participating Medicare provider who has accepted Medicare assignment of claims for services rendered, including any portion to be paid by the Medicare beneficiary as a deductible or coinsurance.

“Medicare cost sharing” means the Medicare member’s responsibility to pay for a Medicare-covered service. “Medicare cost sharing” includes coinsurance, copayments, and deductibles.

“Medicare crossover claim” means a claim for Medicaid payment for services covered by Medicare Part A or Part B rendered to a Medicare beneficiary who is also eligible for Medicaid. Medicare crossover claims include claims for services rendered to beneficiaries who are eligible for Medicaid in any category, including, but not limited to, qualified Medicare beneficiaries and beneficiaries who are eligible for full Medicaid coverage.

“Medicare deductible and coinsurance amounts” means the portion of the Medicare-allowed amount to be paid by the Medicare beneficiary as a deductible or coinsurance.

“Medicare provider reimbursement” means the Medicare-allowed amount less any portion thereof to be paid by the Medicare beneficiary as a deductible or coinsurance.

“Qualified Medicare beneficiary” or *“QMB”* means an individual who has been determined eligible for the QMB program pursuant to 441—paragraph 75.6(5)“a.” Under the QMB program, Medicaid pays the individual’s Medicare Part A and B premiums; coinsurance; copayment; and deductible (except for Part D).

“Third-party payment” means payment from any source other than Medicaid, Medicare, or the Medicaid and Medicare beneficiary.

b. Reimbursement of Medicare crossover claims. Covered Medicare crossover claims will be paid by Medicaid at the lesser of:

(1) Applicable Medicare deductible and coinsurance amounts, less any third-party payment available to the provider for the Medicare deductible and coinsurance amounts and any Medicaid copayment or spenddown; or

(2) Either:

1. For Medicaid-covered services: the Medicaid-allowed amount less the Medicare provider reimbursement, any third-party payment available to the provider in addition to the Medicare provider reimbursement, and any Medicaid copayment or spenddown; or

2. For non-Medicaid-covered services: 50 percent of the Medicare-allowed amount less the Medicare provider reimbursement, any third-party payment available to the provider in addition to the Medicare provider reimbursement, and any Medicaid copayment or spenddown.

79.1(23) and **79.1(24)** Reserved.

79.1(25) *Reimbursement for community mental health centers (CMHCs).* CMHCs may elect to be paid on either a 100 percent of reasonable costs basis, as determined by Medicare reimbursement principles, or in accordance with an alternative reimbursement rate methodology approved by the department. Once a CMHC chooses the alternative reimbursement rate methodology, the CMHC may not change its elected reimbursement methodology to 100 percent of reasonable costs.

a. Cost-based reimbursement. For CMHCs that elect the 100 percent of reasonable costs basis of reimbursement, rates are initially paid on an interim basis and then are adjusted retroactively based on submission of a financial and statistical report, pursuant to the following:

(1) Until a provider that was enrolled in the Medicaid program before October 1, 2006, submits a cost report in order to develop a provider-specific interim rate, Iowa Medicaid will make interim payments to the provider based upon 105 percent of the greater of:

1. The statewide fee schedule for community mental health centers effective July 1, 2006, or

2. The average Medicaid managed care contracted fee amounts for community mental health centers effective July 1, 2006.

(2) For a provider that enrolls in the Medicaid program on or after October 1, 2006, until a provider-specific interim rate is developed, Iowa Medicaid will make interim payments based upon the average statewide interim rates for community mental health centers at the time services are rendered. A new provider may submit a projected cost report that Iowa Medicaid will use to develop a provider-specific interim rate.

(3) Cost reports as filed are subject to review and audit by Iowa Medicaid. Iowa Medicaid will determine each provider’s actual, allowable costs in accordance with generally accepted accounting

principles and in accordance with Medicare cost principles, subject to the exceptions and limitations in the department's administrative rules.

(4) Iowa Medicaid will make retroactive adjustment of the interim rate after the submission of annual cost reports. The adjustment represents the difference between the amount the provider received during the year through interim payments for covered services and the amount determined to be the actual, allowable cost of service rendered to Medicaid members.

(5) Iowa Medicaid will use each annual cost report to develop a provider-specific interim fee schedule to be paid prospectively. The effective date of the fee schedule change is the first day of the month following completion of the cost settlement.

b. Reporting requirements. All providers other than CMHCs that have elected the alternative reimbursement rate methodology established by the Medicaid program's managed care contractor for mental health services shall submit cost reports using a Financial and Statistical Report form. Hospital-based providers required to submit a cost report shall also submit the Medicare cost report, CMS Form 2552. The following requirements apply to all required cost reports:

(1) Financial information shall be based on the provider's financial records. When the records are not kept on an accrual basis of accounting, the provider shall make the adjustments necessary to convert the information to an accrual basis for reporting. Failure to maintain records to support the cost report may result in termination of the provider's enrollment with the Iowa Medicaid program.

(2) Providers that offer multiple programs shall submit a cost allocation schedule prepared in accordance with generally accepted accounting principles and requirements as specified in OMB Circular A-87 adopted in federal regulations at 2 CFR Part 225 as amended to July 1, 2026.

(3) Costs reported for community mental health clinic services shall not be reported as reimbursable costs under any other funding source. Costs incurred for other services shall not be reported as reimbursable costs under community mental health clinic services.

(4) Providers shall submit completed cost reports to Iowa Medicaid at the department's address. A provider that is not hospital-based shall submit a Financial and Statistical Report form on or before the last day of the third month after the end of the provider's fiscal year. A hospital-based provider shall submit both a Financial and Statistical Report form and CMS Form 2552 on or before the last day of the fifth month after the end of the provider's fiscal year.

(5) A provider may obtain a 30-day extension for submitting the cost report by submitting a letter to Iowa Medicaid. No extensions will be granted beyond 30 days.

(6) If a provider fails to submit a cost report that meets the requirements of this paragraph, Iowa Medicaid will reduce the provider's interim payments to 76 percent of the current interim rate. The reduced interim rate will be paid for not longer than three months, after which time no further payments will be made.

79.1(26) *Home health services.*

a. Services included under the home health services program are reimbursed on the low utilization payment amount (LUPA) methodology, with state geographic adjustments.

b. Medicare LUPA per-visit rates in effect on July 1, 2013, are the basis for establishing the LUPA methodology for the initial reimbursement schedule.

c. Medicare LUPA per-visit rates shall be increased July 1 every two years to reflect the most recent Medicare LUPA rates.

d. Home health services subject to this methodology are skilled nursing, home health aide, physical therapy, occupational therapy, speech therapy, and medical social services provided by Medicare-certified home health agencies.

79.1(27) *Reimbursement for early periodic screening, diagnosis, and treatment private duty nursing and personal cares program.*

a. Rate determination based on cost reports. Reimbursement will be made using an hourly rate that is calculated retrospectively for each provider, considering reasonable and proper costs of operation not to exceed the upper limit as provided in subrule 79.1(2).

(1) Interim rates. Providers will be reimbursed through a prospective interim rate equal to the previous year's retrospectively calculated 15-minute and hourly rate. Pending determination of private duty nursing and personal cares program costs, the provider may bill for and shall be reimbursed at an hourly rate that the provider and Iowa Medicaid may reasonably expect to produce total payments to the provider for the provider's fiscal year that are consistent with Medicaid's obligation to reimburse that provider's reasonable costs.

(2) Audit of cost reports. Cost reports as filed will be subject to review or audit or both by Iowa Medicaid to determine the actual cost of services in accordance with generally accepted accounting principles, and Medicare cost principles published in Centers for Medicare and Medicaid Services Publication §15-1, and the Office of Management and Budget Circular A-87, Attachment B, both as amended to July 1, 2026, subject to the exceptions and limitations in the department's administrative rules.

(3) Retroactive adjustment. When the reasonable and proper costs of operation are determined, a retroactive adjustment will be made. The retroactive adjustment represents the difference between the amount that the provider received during the year for covered services through interim rates and the reasonable and proper costs of operation determined in accordance with this subrule.

b. Financial and statistical report submission and reporting requirements.

(1) The provider shall submit the complete Financial and Statistical Report form in an electronic format approved by the department to Iowa Medicaid within five months of the end of the provider's fiscal year.

(2) The submission of the financial and statistical report must include a working trial balance that corresponds to the data contained on the financial and statistical report and the Medicare cost report. Financial and statistical reports submitted without a working trial balance and the Medicare cost report will be considered incomplete.

(3) A provider may obtain a 30-day extension for submitting the financial and statistical report by sending a letter to Iowa Medicaid. The extension request must be received by Iowa Medicaid before the original due date. No extensions will be granted beyond 30 days.

(4) Providers shall submit a completed financial and statistical report to Iowa Medicaid in an electronic format that can be opened using the extension xls orxlsx. The supplemental documentation shall be submitted in a generally accepted business format. The report and required supplemental information shall be emailed to the email address on the form on or before the last day of the fifth month after the end of the provider's fiscal year. One signed copy of the certification page of the Medicaid and Medicare cost reports shall be mailed to Iowa Medicaid at the department's address no later than the due date of the required electronic submissions.

(5) If a provider fails to submit a cost report that meets the requirement of subparagraph 79.1(27)“b”(4), the department will reduce payment to 75 percent of the current rate(s).

1. The reduced rate(s) will be effective the first day of the sixth month following the provider's fiscal year end and will remain in effect until the first day of the month after the delinquent report is received by Iowa Medicaid.

2. The reduced rate(s) will be paid for no longer than three months, after which time no further payments will be made until the first day of the month after the delinquent report is received by Iowa Medicaid.

(6) Financial information shall be based on the provider's financial records. When the records are not kept on an accrual basis of accounting, the provider shall make the adjustments necessary to convert the information to an accrual basis for reporting and provide documentation detailing these adjustments. Failure to maintain records to support the cost report may result in the following, but not limited to:

1. Recoupment of Medicaid payments.
2. Penalties.
3. Sanctions pursuant to rule 441—79.2(249A).

(7) The department, in its sole discretion, may on its own initiative reopen a review of a financial and statistical report at any time. No other entity or person has the right to request that the department or its contractor reopen a review of a financial and statistical report, or to submit an amended financial and statistical report for review by the department, after the provider is notified of its reimbursement rates following review of a financial and statistical report.

(8) A projected cost report shall be submitted when a home health agency enters the program or adds private duty nursing and the personal cares program. Prospective interim rates will be established using the projected cost report. The effective date of the rate shall be the day the provider becomes certified as a Medicaid provider or the day the new program is added.

(9) A provider of services under multiple programs shall submit a cost allocation schedule that was used during the preparation of the financial and statistical report.

(10) Costs reported under private duty nursing and the personal cares program shall not be reported as reimbursable costs under any other funding source. Costs incurred for other services shall not be reported as reimbursable costs under private duty nursing and the personal cares program.

(11) When a provider continues to include as an item of cost an item or items that had in a prior period been removed by an adjustment by the department or its contractor, in the total program costs, the contractor shall recommend to the department that the reimbursement rates be reduced to 75 percent of the current reimbursement rate for the entire quarter beginning the first day of the sixth month after the provider's fiscal year end. The department may, after considering the seriousness of the exception, make the reduction.

(12) Nothing in this subrule relieves a provider of its obligation to immediately inform the department that it has retained Medicaid funds to which it is not entitled as a result of any cost report process. A provider must notify Iowa Medicaid when the provider notes that funds are incorrectly paid or when an overpayment has been detected.

c. Terminated home health agencies.

(1) A participating home health agency contemplating termination of private duty nursing and the personal cares program shall provide the department with at least 60 days' prior notice. The person responsible for the termination is responsible for submission of a final financial and statistical report through the date of the termination. The final home health cost report shall meet the reporting requirements in paragraph 79.1(27) "b."

(2) For facilities that terminate activity with Iowa Medicaid, a financial and statistical report from the beginning of the fiscal year to the date of termination will be required, regardless of if termination is voluntary, involuntary or due to a change in ownership. All documentation in paragraph 79.1(27) "a" shall be submitted 45 days after the date of termination, by the terminated (closed) entity. If no report is received within 45 days, Iowa Medicaid will begin the process to recoup all funds for dates of service beginning from the last filed cost report to the date of termination.

79.1(28) *Reimbursement for community-based neurobehavioral rehabilitation residential services and community-based neurobehavioral rehabilitation intermittent services.*

a. New providers. Providers who are newly enrolled will be paid prospective rates based on projected reasonable and proper costs of operation based on the statewide average rate paid to community-based neurobehavioral rehabilitation service providers in effect June 30 each fiscal year.

b. Established providers. After establishment of the initial rate for a provider, the rate will be adjusted annually, effective July 1 each year. The provider's new rate will be the previously established rate adjusted by the consumer price index for all urban consumers for the preceding 12-month period ending June 30, not to exceed the limit in effect June 30.

79.1(29) *Reimbursement for health insurance premium payment (HIPP) program providers.* Reimbursement for HIPP program providers will be provided only when such provider is enrolled with Iowa Medicaid for the sole purpose of billing HIPP-eligible in-network coinsurance, copayments, and deductibles.

a. Definitions. For purposes of this subrule:

"Coinsurance" means a percentage of costs of a covered health care service that has to be paid.

“Copayment” means a fixed amount a member pays for a covered health care service.

“Deductible” means the amount paid for covered health care services before the insurance plan starts to pay.

“Eligible member” means an individual eligible for Medicaid pursuant to rule 441—75.1(249A) et seq. and who qualifies for and is participating in the department’s HIPP program prescribed under rule 441—75.21(249A).

“Health insurance premium payment (HIPP) program” or *“HIPP program”* has the same meaning as provided in rule 441—75.21(249A).

b. Claim submission. To submit a claim for reimbursement, a HIPP provider shall use a Health Insurance Premium Payment (HIPP) Provider Invoice form.

(1) Payment will be made to eligible providers for a HIPP program-eligible member’s coinsurance, copayment, and deductible when the HIPP program-eligible member is active on the date of service.

(2) Member responsibility. The eligible member may be responsible for a copayment pursuant to subrule 79.1(13).

79.1(30) Tiered rates. For daily supported community living services, residential-based supported community living services, full-day habilitation services, and adult day care services provided under the intellectual disability waiver, the fee schedule published by the department pursuant to paragraph 79.1(1) “c” provides rates based on the acuity tier of the member, as determined pursuant to this subrule.

a. Acuity tiers are based on the results of the interRAI-Intellectual Disability (interRAI-ID) for individuals age 18 and over and the Child and Youth Mental Health Developmental Disability (ChYMH-DD) (for children and youth below age 18) assessment tools as amended to July 1, 2026. The completed interRAI assessment tool and scoring criteria are available on request from Iowa Medicaid.

b. The assignment of members to acuity tiers is based on a mathematically valid process that identifies meaningful differences in the support needs of the members based on the InterRAI-ID and ChYMH-DD scores.

c. For supported community living daily services paid through a per diem, there are two reimbursement sublevels within each tier based on the number of hours of day services a member receives monthly. Day services include enhanced job search services, supported employment, prevocational services, adult day care, day habilitation and employment outside of Medicaid reimbursable services. The two reimbursement sublevels reflect reimbursement for:

- (1) Members who receive an average of 40 hours or more of day services per month.
- (2) Members who receive an average of less than 40 hours of day services per month.

d. Acuity tier scores are derived from information contained in the following sections:

- (1) Section A. Identification Information
- (2) Section B. Intake and Initial History
- (3) Section C. Community and Social Involvement
- (4) Section D. Strengths, Relationships, and Supports
- (5) Section E. Lifestyle
- (6) Section F. Environmental Assessment
- (7) Section G. Communication and Vision
- (8) Section H. Cognition or Section I. Health Conditions
- (9) Section N. Supports and Services

e. Tier redetermination. A member’s acuity tier may be changed in the following circumstances:

(1) There is a change in the member’s interRAI-ID or ChYMH-DD score as determined in the annual level of care redetermination process pursuant to rule 441—83.64(249A).

(2) A completed Emergency Needs Assessment form indicates a change in the member’s support needs. A member’s case manager may request an emergency needs assessment when a significant change in the member’s needs is identified. When a completed emergency needs assessment indicates

significant changes that are likely to continue, a full interRAI-ID or ChYMH-DD assessment shall be conducted and any change in the interRAI-ID or ChYMH-DD scores will be used to determine the member's acuity tier.

[ARC 0316D, IAB 5/27/26, effective 7/1/26]

441—79.2(249A) Sanctions.

79.2(1) Definitions.

"Affiliates" means persons having an overt or covert relationship such that any one of them directly or indirectly controls or influences or has the power to control or influence another.

"Iowa Medicaid" means the entity comprised of department staff and contractors responsible for the management and reimbursement of Medicaid services for the benefit of Medicaid members.

"Person" means any individual human being or any company, firm, association, corporation, institution, or other legal entity. "Person" includes but is not limited to a provider and any affiliate of a provider.

"Probation" means a specified period of conditional participation in the medical assistance program.

"Provider" means an individual human being, firm, corporation, association, institution, or other legal entity that is providing or has been approved to provide medical assistance to a member pursuant to the state medical assistance program.

"Suspension from participation" means an exclusion from participation for a specified period of time.

"Suspension of payments" means the temporary cessation of payments due a person until the resolution of a matter in dispute between a person and the department.

"Termination from participation" means a permanent exclusion from participation in the medical assistance program.

"Withholding of payments" means a reduction or adjustment of the amounts paid to a person on pending and subsequently submitted bills for purposes of offsetting payments made to, received by, or in the possession of a person.

79.2(2) Grounds for sanctions. The department may impose sanctions against any person when appropriate. Appropriate grounds for the department to impose sanctions include but are not limited to the following:

a. Presenting or causing to be presented for payment any false, intentionally misleading, or fraudulent claim for services or merchandise.

b. Submitting or causing to be submitted false, intentionally misleading, or fraudulent information for the purpose of obtaining greater compensation than that to which the person is legally entitled, including charges in excess of usual and customary charges.

c. Submitting or causing to be submitted false, intentionally misleading, or fraudulent information for the purpose of meeting prior authorization or level of care requirements.

d. Upon lawful demand, failing to disclose or make available to the department, the department's authorized agent, any law enforcement or peace officer, any agent of the department of inspections, appeals, and licensing's Medicaid fraud control unit, any agent of the auditor of state, the Iowa department of justice, any false claims investigator as defined under Iowa Code chapter 685, or any other duly authorized federal or state agent or agency records of services provided to medical assistance members or records of payments made for those services.

e. Failing to provide or maintain quality services, or a requisite assurance of a framework of quality services to medical assistance recipients within accepted medical community standards as adjudged by professional peers if applicable. For purposes of this subrule, "quality services" means services provided in accordance with the applicable rules and regulations governing the services.

f. Engaging in a course of conduct or performing an act that is in violation of any federal, state, or local statute, rule, regulation, or ordinance, or an applicable contractual provision, that relates to, or

arises out of, any publicly or privately funded health care program, including but not limited to any state medical assistance program.

g. Submitting a false, intentionally misleading, or fraudulent certification or statement, whether the certification or statement is explicit or implied, to the department or the department's representative or to any other publicly or privately funded health care program.

h. Overutilization of the medical assistance program by inducing, furnishing or otherwise causing a member to receive services or merchandise not required or requested.

i. Violating any provision of Iowa Code chapter 249A, or any rule promulgated pursuant thereto, or violating any federal or state false claims Act, including but not limited to Iowa Code chapter 685.

j. Submitting or causing to be submitted false, intentionally misleading, or fraudulent information in an application for provider status under the medical assistance program or any quality review or other submission required to maintain good standing in the program.

k. Violating any law, regulation, or code of ethics governing the conduct of an occupation, profession, or other regulated business activity, when the violation relates to, or arises out of, the delivery of services under the state medical assistance program.

l. Breaching any settlement or similar agreement with the department or failing to abide by the terms of any agreement with any other entity relating to, or arising out of, the state medical assistance program.

m. Failing to meet standards required by state or federal law for participation, including but not limited to licensure.

n. Exclusion from Medicare or any other state or federally funded medical assistance program.

o. Except as authorized by law, charging a person for covered services over and above what the department paid or would pay or soliciting, offering, or receiving a kickback, bribe, or rebate, or accepting or rebating a fee or a charge for medical assistance or patient referral, or a portion thereof. This ground does not include the collection of a copayment or deductible if otherwise allowed by law.

p. Failing to correct a deficiency in provider operations after receiving notice of the deficiency from the department or other federal or state agency.

q. Formal reprimand or censure by an association of the provider's peers or similar entity related to professional conduct.

r. Suspension or termination for cause from participation in another program, including but not limited to workers' compensation or any publicly or privately funded health care program.

s. Indictment or other institution of criminal charges for, or plea of guilty or nolo contendere to, or conviction of, any crime punishable by a term of imprisonment greater than one year, any crime of violence, any controlled substance offense, or any crime involving an allegation of dishonesty or negligent practice resulting in death or injury to a provider's patient.

t. Violation of a condition of probation, suspension of payments, or other sanction.

u. Loss, restriction, or lack of hospital privileges for cause.

v. Negligent, reckless, or intentional endangerment of the health, welfare, or safety of a person.

w. Billing for services provided by an excluded, nonenrolled, terminated, suspended, or otherwise ineligible provider or person.

x. Failing to submit a self-assessment, corrective action plan, or other requirement for continued participation in the medical assistance program, or failing to repay an overpayment of medical assistance funds, in a timely manner, as set forth in a rule or other order.

y. Attempting, aiding or abetting, conspiring, or knowingly advising or encouraging another person in the commission of one or more of the grounds specified herein.

79.2(3) Sanctions.

a. The department may impose any of the following sanctions on any person:

(1) A term of probation for participation in the medical assistance program.

(2) Termination from participation in the medical assistance program.

(3) Suspension from participation in the medical assistance program.

- (4) Suspension of payments in whole or in part.
- (5) Prior authorization of services.
- (6) Review of claims prior to payment.

b. The withholding of a payment or a recoupment of medical assistance funds is not, in itself, a sanction. Overpayments, civil monetary penalties, and interest may also be withheld from payments without imposition of a sanction.

c. Mandatory suspensions and terminations.

(1) Suspension or termination from participation in the medical assistance program is mandatory when a person is suspended or terminated from participation in the Medicare program, another state's medical assistance program, or by any licensing body. The suspension or termination from participation in the medical assistance program will be retroactive to the date established by the CMS or other state or body and, in the case of a suspension, must continue until at least such time as the Medicare or other state's or body's suspension ends.

(2) Termination is mandatory upon entry of final judgment, in the Iowa district court or a federal district court of the United States, of liability of the person in a false claims action.

(3) Suspension from participation is mandatory whenever a person, or an affiliate of the person, has an outstanding overpayment of medical assistance funds, as defined in Iowa Code chapter 249A.

(4) Upon notification from the U.S. Department of Justice, the department of justice, the department of inspections, appeals, and licensing, or a similar agency that a person has failed to respond to a civil investigative demand or other subpoena in a timely manner as set forth in governing law and the demand or other subpoena itself, the department will immediately suspend the person from participation and suspend all payments to the person. The suspension and payment suspension will end upon notification that the person has responded to the demand in full.

79.2(4) *Imposition and extent of sanction.* The department will consider the totality of the circumstances in determining the sanctions to be imposed. The factors the department may consider include but are not limited to:

- a. Seriousness of the offense.
- b. Extent of violations.
- c. History of prior violations.
- d. Prior imposition of sanctions.
- e. Prior provision of provider education (technical assistance).
- f. Provider willingness to obey program rules.
- g. Whether a lesser sanction will be sufficient to remedy the problem.
- h. Actions taken or recommended by peer review groups or licensing boards.

79.2(5) *Scope of sanction.*

a. Suspension or termination from participation shall preclude the person from submitting claims for payment, whether personally or through claims submitted by any other person or affiliate, for any services or supplies except for those services provided before the suspension or termination.

b. No person may submit claims for payment for any services or supplies provided by a person or affiliate who has been suspended or terminated from participation in the medical assistance program except for those services provided before the suspension or termination.

c. When the provisions of this subrule are violated, the department may sanction any person responsible for the violation.

79.2(6) *Notice to third parties.* When a sanction is imposed, the department may notify third parties of the findings made and the sanction imposed, including but not limited to law enforcement or peace officers and federal or state agencies. The imposition of a sanction is not required before the department may notify third parties of a person's conduct. In accordance with 42 CFR §1002.212 as amended to July 1, 2026, the department must notify other state agencies, applicable licensing boards, the public, and Medicaid members as provided in 42 CFR §1001.2005 and 1001.2006, both as amended to July 1, 2026, whenever the department initiates an exclusion under 42 CFR §1002.210 as amended to July 1, 2026.

79.2(7) *Notice of violation.*

a. Any order of sanction will be in writing and include the name of the person subject to sanction, identify the ground for the sanction and its effective date, and be sent to the person's last-known address. If the department sanctions a provider, the order of sanction will also include the national provider identification number of the provider and be sent to the provider's last address on file within the medical assistance program. Proof of mailing to such address shall be conclusive evidence of proper service of the sanction upon the provider.

b. In the case of a currently enrolled provider otherwise in good standing with all program requirements, the provider shall have 15 days subsequent to the date of the notice prior to the department action to show cause why the action should not be taken. If the provider fails to do so, the sanction will remain effective pending any subsequent appeal under 441—Chapter 2506. If the provider attempts to show cause but the department determines the sanction should remain effective pending any subsequent appeal under 441—Chapter 2506, the provider may seek a temporary stay of the department's action from the director or the director's designee by filing an application for stay with the department. The director or the director's designee shall consider the factors listed in Iowa Code section 17A.19(5) "c."

79.2(8) *Suspension or withholding of payments.* The department may withhold payments on pending and subsequently received claims in an amount reasonably calculated to approximate the amounts in question due to a sanction, incorrect payment, civil monetary penalty, or other adverse action and may also suspend payment or participation pending a final determination. If the department withholds or suspends payments, it will notify the person in writing within the time frames prescribed by federal law for cases related to a credible allegation of fraud, and within ten days for all other cases.

79.2(9) *Civil monetary penalties and interest.* Civil monetary penalties and interest assessed in accordance with Iowa Code section 249A.11 or 249A.47 are not allowable costs for any aspect of determining payment to a person within the medical assistance program. Under no circumstance will the department reimburse a person for such civil monetary penalties or interest.

79.2(10) *Report and return of identified overpayment.*

a. If a person has identified an overpayment, the person must report and return the overpayment in the form and manner set forth in this subrule.

b. A person has identified an overpayment if the person has actual knowledge of the existence of the overpayment or acts in reckless disregard or deliberate ignorance of the existence of the overpayment.

c. An overpayment required to be reported under Iowa Code section 249A.39 must be made in writing, addressed to Iowa Medicaid, and contain all of the following:

- (1) Person's name.
- (2) Person's tax identification number.
- (3) How the error was discovered.
- (4) The reason for the overpayment.
- (5) Claim number(s), as appropriate.
- (6) Date(s) of service.
- (7) Member identification number(s).
- (8) National provider identification (NPI) number.
- (9) Description of the corrective action plan to ensure the error does not occur again, if applicable.
- (10) Whether the person has a corporate integrity agreement with the Office of the Inspector General (OIG) or is under the OIG Self-Disclosure Protocol or is presently under sanction by the department.
- (11) The time frame and the total amount of refund for the period during which the problem existed that caused the refund.

(12) If a statistical sample was used to determine the overpayment amount, a description of the statistically valid methodology used to determine the overpayment.

(13) A refund in the amount of the overpayment.

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441—79.3(249A) Maintenance of records by providers of service. A provider of a service that is charged to the medical assistance program shall maintain complete and legible records as required in this rule. Failure to maintain records or failure to make records available to the department or to its authorized representative timely upon request shall result in claim denial or recoupment.

79.3(1) *Financial (fiscal) records.*

a. A provider of service shall maintain records as necessary to:

(1) Support the determination of the provider's reimbursement rate under the medical assistance program; and

(2) Support each item of service for which a charge is made to the medical assistance program. These records include financial records and other records as may be necessary for reporting and accountability.

b. A financial record does not constitute a medical record.

79.3(2) *Medical (clinical) records.* A provider of service shall maintain complete and legible medical records for each service for which a charge is made to the medical assistance program. Required records shall include any records required to maintain the provider's license in good standing.

a. Definition. "Medical record" (also called "clinical record") means a tangible history that provides evidence of:

(1) The provision of each service and each activity billed to the program; and

(2) First and last name of the member receiving the service.

b. Purpose. The medical record shall provide evidence that the service provided is:

(1) Medically necessary;

(2) Consistent with the diagnosis of the member's condition; and

(3) Consistent with professionally recognized standards of care.

c. Components.

(1) Identification. Each page or separate electronic document of the medical record shall contain the member's first and last name. In the case of electronic documents, the member's first and last name must appear on each screen when viewed electronically and on each page when printed. As part of the medical record, the medical assistance identification number and the date of birth must also be identified and associated with the member's first and last name.

(2) Basis for service—general rule. General requirements for all services are listed herein. For the application of these requirements to specific services, see paragraph 79.3(2) "d." The medical record shall reflect the reason for performing the service or activity, substantiate medical necessity, and demonstrate the level of care associated with the service. The medical record shall include the items specified below unless the listed item is not routinely received or created in connection with a particular service or activity and is not required to document the reason for performing the service or activity, the medical necessity of the service or activity, or the level of care associated with the service or activity:

1. The member's complaint, symptoms, and diagnosis.

2. The member's medical or social history.

3. Examination findings.

4. Diagnostic test reports, laboratory test results, or X-ray reports.

5. Goals or needs identified in the member's plan of care.

6. Physician orders and any prior authorizations required for Medicaid payment.

7. Medication records, pharmacy records for prescriptions, or providers' orders.

8. Related professional consultation reports.

9. Progress or status notes for the services or activities provided.
10. All forms required by the department as a condition of payment for the services provided.
11. Any treatment plan, care plan, service plan, individual health plan, behavioral intervention plan, or individualized education program.
12. The provider's assessment, clinical impression, diagnosis, or narrative, including the complete date thereof and the identity of the person performing the assessment, clinical impression, diagnosis, or narrative.
13. Any additional documentation necessary to demonstrate the medical necessity of the service provided or otherwise required for Medicaid payment.

(3) Service documentation. The record for each service provided shall include information necessary to substantiate that the service was provided. Unless otherwise indicated below, the provider may document the services in any format so long as the documentation adequately substantiates the medical necessity and that the services were rendered. The service record shall include the following:

1. The specific procedures or treatments performed.
2. The complete date of the service, including the beginning and ending date if the service is rendered over more than one day.
3. The complete time of the service, including the beginning and ending time if the service is billed on a time-related basis. For those non-time-related services billed using Current Procedural Terminology (CPT) codes, the total time of the service shall be recorded, rather than the beginning and ending time.
4. The location where the service was provided if otherwise required on the billing form or in 441—paragraph 77.35(5) “c” or “d,” 441—paragraph 77.42(12) “e,” or 441—numbered paragraph 78.9(10) “a”(1) “2,” first bullet point.
5. Medication administration record (MAR). The name, dosage, and route of administration of any medication dispensed or administered as part of the service.
6. Mileage log. The name, date, purpose of the trip, and total miles for transportation provided as part of the service.
7. Narrative description of any incidents or illnesses or unusual or atypical occurrences that occur during service provision.
8. Any supplies dispensed as part of the service.
9. The first and last name and professional credentials, if any, of the person providing the service.
10. The signature of the person providing the service, or the initials of the person providing the service if a signature log indicates the person's identity.
11. For 24-hour care, documentation for every shift of the services provided.

(4) Outcome of service. The medical record shall indicate the member's progress in response to the services rendered, including any changes in treatment, alteration of the plan of care, or revision of the diagnosis.

d. Basis for service requirements for specific services. The health care provider should include all records and documentation that substantiate the services provided to the member and all information necessary to allow accurate adjudication of the claim. Additionally, documentation requirements must meet the professional standards pertaining to the service provided. The medical record for the following services must include but is not limited to the items specified below (unless the listed item is not routinely received or created in connection with the particular service or activity and is not required to document the reason for performing the service or activity, its medical necessity, or the level of care associated with it).

- (1) Physician (MD and DO) services:
 1. Service or office notes or narratives.
 2. Procedure, laboratory, or test orders and results.
- (2) Pharmacy services:
 1. Prescriptions.

2. Nursing facility physician order.
3. Telephone order.
4. Pharmacy notes.
5. Prior authorization documentation.
- (3) Dentist services:
 1. Treatment notes.
 2. Anesthesia notes and records.
 3. Prescriptions.
- (4) Podiatrist services:
 1. Service or office notes or narratives.
 2. Certifying physician statement.
 3. Prescription or order form.
- (5) Certified registered nurse anesthetist services:
 1. Service notes or narratives.
 2. Preanesthesia physical examination report.
 3. Operative report.
 4. Anesthesia record.
 5. Prescriptions.
- (6) Other advanced registered nurse practitioner services:
 1. Service or office notes or narratives.
 2. Procedure, laboratory, or test orders and results.
 3. Other service documentation as applicable.
- (7) Optometrist and optician services:
 1. Notes or narratives supporting eye examinations, medical services, and auxiliary procedures.
 2. Original prescription or updated prescriptions for corrective lenses or contact lenses.
 3. Prior authorization documentation.
- (8) Psychologist services:
 1. Service or office psychotherapy notes or narratives.
 2. Psychological examination report and notes.
 3. Other service documentation as applicable.
- (9) Clinic services:
 1. Service or office notes or narratives.
 2. Procedure, laboratory, or test orders and results.
 3. Nurses' notes.
 4. Prescriptions.
 5. Medication administration records.
- (10) Services provided by rural health clinics or federally qualified health centers:
 1. Service or office notes or narratives.
 2. Prenatal Risk Assessment form.
 3. Procedure, laboratory, or test orders and results.
 4. Immunization records.
- (11) Services provided by community mental health centers:
 1. Service referral documentation.
 2. Initial evaluation.
 3. Individual treatment plan.
 4. Service or office notes or narratives.
 5. Narratives related to the peer review process and peer review activities related to a member's treatment.
6. Written plan for accessing emergency services.
7. Other service documentation as applicable.
- (12) Screening center services:

1. Service or office notes or narratives.
2. Immunization records.
3. Laboratory reports.
4. Results of health, vision, or hearing screenings.
- (13) Family planning services:
 1. Service or office notes or narratives.
 2. Procedure, laboratory, or test orders and results.
 3. Nurses' notes.
 4. Immunization records.
 5. Consent forms.
 6. Prescriptions.
 7. Medication administration records.
- (14) Maternal health center services:
 1. Service or office notes or narratives.
 2. Procedure, laboratory, or test orders and results.
 3. Prenatal Risk Assessment form.
- (15) Birthing center services:
 1. Service or office notes or narratives.
 2. Prenatal Risk Assessment form.
- (16) Ambulatory surgical center services:
 1. Service notes or narratives (history and physical, consultation, operative report, or discharge summary).
 2. Physician orders.
 3. Consent forms.
 4. Anesthesia records.
 5. Pathology reports.
 6. Laboratory and X-ray reports.
- (17) Hospital services:
 1. Physician orders.
 2. Service notes or narratives (history and physical, consultation, operative report, or discharge summary).
 3. Progress or status notes.
 4. Diagnostic procedures, including laboratory and X-ray reports.
 5. Pathology reports.
 6. Anesthesia records.
 7. Medication administration records.
- (18) State mental hospital services:
 1. Service referral documentation.
 2. Resident assessment and initial evaluation.
 3. Individual comprehensive treatment plan.
 4. Service notes or narratives (history and physical, therapy records, discharge summary).
 5. Case Activity Report form.
 6. Medication administration records.
- (19) Services provided by skilled nursing facilities, nursing facilities, and nursing facilities for persons with mental illness:
 1. Physician orders.
 2. Progress or status notes.
 3. Service notes or narratives.
 4. Procedure, laboratory, or test orders and results.
 5. Nurses' notes.
 6. Physical therapy, occupational therapy, and speech therapy notes.

7. Medication administration records.
8. Case Activity Report form.
- (20) Services provided by intermediate care facilities for persons with mental retardation:
 1. Physician orders.
 2. Progress or status notes.
 3. Preliminary evaluation.
 4. Comprehensive functional assessment.
 5. Individual program plan.
 6. Resident Care Agreement form.
 7. Program documentation.
 8. Medication administration records.
 9. Nurses' notes.
 10. Case Activity Report form.
- (21) Services provided by psychiatric medical institutions for children:
 1. Physician orders or court orders.
 2. Independent assessment.
 3. Individual treatment plan.
 4. Service notes or narratives (history and physical, therapy records, discharge summary).
 5. Case Activity Report form.
 6. Medication administration records.
- (22) Hospice services:
 1. Physician certifications for hospice care.
 2. Election of Medicaid Hospice Benefit form.
 3. Revocation of Medicaid Hospice Benefit form.
 4. Plan of care.
 5. Physician orders.
 6. Progress or status notes.
 7. Service notes or narratives.
 8. Medication administration records.
 9. Prescriptions.
- (23) Services provided by rehabilitation agencies:
 1. Physician orders.
 2. Initial certification, recertifications, and treatment plans.
 3. Narratives from treatment sessions.
 4. Treatment and daily progress or status notes and forms.
- (24) Home- and community-based habilitation services:
 1. Notice of decision for service authorization.
 2. Service plan (initial and subsequent).
 3. Service notes or narratives.
 4. Other service documentation as applicable.
- (25) Behavioral health intervention:
 1. Order for services.
 2. Comprehensive treatment or service plan (initial and subsequent).
 3. Service notes or narratives.
 4. Other service documentation as applicable.
- (26) Services provided by area education agencies and local education agencies:
 1. Service notes or narratives.
 2. Individualized education program (IEP).
 3. Individual health plan (IHP).
 4. Behavioral intervention plan.
- (27) Home health agency services:

1. Plan of care or plan of treatment.
 2. Certifications and recertifications.
 3. Service notes or narratives.
 4. Physician, nurse practitioner, physician associate, or clinical nurse specialist orders or medical orders.
- (28) Services provided by independent laboratories:
1. Laboratory reports.
 2. Physician order for each laboratory test.
- (29) Ambulance services:
1. Documentation on the claim or run report supporting medical necessity of the transport.
 2. Documentation supporting mileage billed.
- (30) Services of lead investigation agencies:
1. Service notes or narratives.
 2. Child's lead level logs (including laboratory results).
 3. Written investigation reports to family, owner of building, child's medical provider, and local childhood lead poisoning prevention program.
 4. Health education notes, including follow-up notes.
- (31) Medical supplies:
1. Prescriptions.
 2. Certificate of medical necessity.
 3. Prior authorization documentation.
 4. Medical equipment invoice or receipt.
- (32) Orthopedic shoe dealer services:
1. Service notes or narratives.
 2. Prescriptions.
 3. Certifying physician's statement.
- (33) Case management services, including HCBS case management services:
1. Notice of decision for service authorization.
 2. Service notes or narratives.
 3. Social history.
 4. Comprehensive service plan.
 5. Reassessment of member needs.
 6. Incident reports in accordance with 441—subrule 24.4(5).
 7. Other service documentation as applicable.
- (34) Early access service coordinator services:
1. Individualized family service plan (IFSP).
 2. Service notes or narratives.
- (35) Home- and community-based waiver services, other than case management:
1. Notice of decision for service authorization.
 2. Service plan.
 3. Service logs, notes, or narratives.
 4. Mileage and transportation logs.
 5. Log of meal delivery.
 6. Invoices or receipts.
 7. HCBS Attendant Care Agreement and Attendant Care Service Record.
 8. Other service documentation as applicable.
- (36) Physical therapist services:
1. Physician order for physical therapy.
 2. Initial physical therapy certification, recertifications, and treatment plans.
 3. Treatment notes and forms.
 4. Progress or status notes.

- (37) Chiropractor services:
 - 1. Service or office notes or narratives.
 - 2. X-ray results.
- (38) Hearing aid dealer and audiologist services:
 - 1. Physician examinations and audiological testing form.
 - 2. Waiver of informed consent.
 - 3. Prior authorization documentation.
 - 4. Service or office notes or narratives.
- (39) Behavioral health services:
 - 1. Assessment.
 - 2. Individual treatment plan.
 - 3. Service or office notes or narratives.
 - 4. Other service documentation as applicable.
- (40) Reserved.
- (41) Services of public health agencies:
 - 1. Service or office notes or narratives.
 - 2. Immunization records.
 - 3. Results of communicable disease testing.
- (42) Community-based neurobehavioral rehabilitation residential services and community-based neurobehavioral rehabilitation intermittent services:
 - 1. Department-approved standardized neurobehavioral assessment tool.
 - 2. Community-based neurobehavioral treatment order.
 - 3. Treatment plan.
 - 4. Clinical records documenting diagnosis and treatment history.
 - 5. Progress or status notes.
 - 6. Service notes or narratives.
 - 7. Procedure, laboratory, or test orders and results.
 - 8. Therapy notes including but not limited to occupational therapy, physical therapy, and speech-language pathology services as applicable.
 - 9. Medication administration records.
 - 10. Other service documentation as applicable.
- (43) Child care medical services:
 - 1. Plan of care.
 - 2. Certification and recertification.
 - 3. Service notes or narratives.
 - 4. Physician orders or medical orders.
 - 5. Abbreviation list (a copy of the abbreviation list utilized within the member's record).
 - 6. If initials or incomplete signatures are noted within the member's record, a signature log (a typed listing of each provider's name, including initials, professional credentials and title, followed by the individual provider's signature).
- (44) Subacute mental health services.
 - 1. Physician orders or court orders.
 - 2. Independent assessment.
 - 3. Individual treatment plan.
 - 4. Service notes or narratives (history and physical, therapy records, discharge summary).
 - 5. Medication administration records (residential services).
- (45) Crisis response services, crisis stabilization community-based services and crisis stabilization residential services.
 - 1. Assessment.
 - 2. Individual stabilization plan.
 - 3. Service notes or narratives (history and physical, therapy records, discharge summary).

4. Medication administration records (residential services).

e. *Corrections.* A provider may correct the medical record before submitting a claim for reimbursement.

(1) Corrections must be made or authorized by the person who provided the service or by a person who has first-hand knowledge of the service.

(2) A correction to a medical record must not be written over or otherwise obliterate the original entry. A single line may be drawn through erroneous information, keeping the original entry legible. In the case of electronic records, the original information must be retained and retrievable.

(3) Any correction must indicate the person making the change and any other person authorizing the change, must be dated and signed by the person making the change, and must be clearly connected with the original entry in the record.

(4) If a correction made after a claim has been submitted affects the accuracy or validity of the claim, an amended claim must be submitted.

79.3(3) Maintenance requirement. The provider shall maintain records as required by this rule:

a. During the time the member is receiving services from the provider.

b. For a minimum of five years from the date when a claim for the service was submitted to the medical assistance program for payment.

c. As may be required by any licensing authority or accrediting body associated with determining the provider's qualifications.

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441—79.4(249A) Reviews and audits.

79.4(1) Definitions.

"Authorized representative," within the context of this rule, means the person appointed to carry out audit or review procedures, including assigned auditors, reviewers or agents contracted for specific audits, reviews, or audit or review procedures.

"Claim" means each record received by the department or Iowa Medicaid that states the amount of requested payment and the service rendered by a specific and particular Medicaid provider to an eligible member.

"Clinical record" means a legible electronic or hard-copy history that documents the criteria established for medical records as set forth in rule 441—79.3(249A). A claim form or billing statement does not constitute a clinical record.

"Confidence level" means the statistical reliability of the sampling parameters used to estimate the proportion of payment errors (overpayment and underpayment) in the universe under review.

"Customary and prevailing fee" means a fee that is both (1) the most consistent charge by a Medicaid provider for a given service and (2) within the range of usual charges for a given service billed by most providers with similar training and experience in the state of Iowa.

"Extrapolation" means that the total amount of overpayment or underpayment will be determined by using sample data meeting the confidence level requirement.

"Fiscal record" means a legible electronic or hard-copy history that documents the criteria established for fiscal records as set forth in rule 441—79.3(249A). A claim form or billing statement does not constitute a fiscal record.

"Overpayment" means any payment or portion of a payment made to a provider that is incorrect according to the laws and rules applicable to the Medicaid program and that results in a payment greater than that to which the provider is entitled.

"Procedure code" means the identifier that describes medical or remedial services performed or the supplies, drugs, or equipment provided.

"Random sample" means a statistically valid random sample for which the probability of selection for every item in the universe is known.

“Underpayment” means any payment or portion of a payment not made to a provider for services delivered to eligible members according to the laws and rules applicable to the Medicaid program and to which the provider is entitled.

“Universe” means all items or claims under review or audit during the period specified by the audit or review.

79.4(2) *Audit or review of clinical and fiscal records by the department.* Any Medicaid provider may be audited or reviewed at any time at the discretion of the department.

a. Authorized representatives of the department have the right, upon proper identification, to audit or review the clinical and fiscal records to determine whether:

- (1) The department has correctly paid claims for goods or services.
- (2) The provider has furnished the services to Medicaid members.
- (3) The provider has retained clinical and fiscal records that substantiate claims submitted for payment.
- (4) The goods or services provided were in accordance with Iowa Medicaid policy.

b. Requests for provider records by Iowa Medicaid will include a Documentation Checklist form, which is available on the department’s website, listing the specific records that must be provided for the audit or review pursuant to paragraph 79.3(2) “*d*” to document the basis for services or activities provided.

c. Records generated and maintained by the department may be used by auditors or reviewers and in all proceedings of the department.

79.4(3) *Audit or review procedures.* The department will select the method of conducting an audit or review and will protect the confidential nature of the records being audited or reviewed. The provider may be required to furnish records to the department. Unless the department specifies otherwise, the provider may select the method of delivering any requested records to the department.

a. Upon a written request for records, the provider must submit all responsive records to the department or its authorized agent within 30 calendar days of the mailing date of the request, except as provided in paragraph 79.4(3) “*b*.”

b. Extension of time limit for submission.

(1) The department may grant an extension to the required submission date of up to 15 calendar days upon written request from the provider or the provider’s designee. The request must:

1. Establish good cause for the delay in submitting the records; and
2. Be received by the department before the date the records are due to be submitted.

(2) For purposes of these rules, “good cause” has the same meaning as in Iowa Rule of Civil Procedure 1.977.

(3) The department may grant a request for an extension of the time limit for submitting records at its discretion. The department shall issue a written notice of its decision.

(4) The provider may appeal the department’s denial of a request to extend the time limit for submission of requested records according to the procedures in 441—Chapter 2506.

c. The department may elect to conduct announced or unannounced on-site reviews or audits. Records must be provided upon request and before the end of the on-site review or audit.

(1) For an announced on-site review or audit, the department’s employee or authorized agent may give as little as one day’s advance notice of the review or audit and the records and supporting documentation to be reviewed.

(2) Notice is not required for unannounced on-site reviews and audits.

(3) In an on-site review or audit, the conclusion of that review or audit is considered the end of the period within which to produce records.

d. Audit or review procedures may include, but are not limited to, the following:

- (1) Comparing clinical and fiscal records with each claim.
- (2) Interviewing members who received goods or services and employees of providers.
- (3) Examining third-party payment records.

(4) Comparing Medicaid charges with private-patient charges to determine that the charge to Medicaid is not more than the customary and prevailing fee.

(5) Examining all documents related to the services for which Medicaid was billed.

e. Use of statistical sampling techniques. The department's procedures for auditing or reviewing Medicaid providers may include the use of random sampling and extrapolation.

(1) A statistically valid random sample will be selected from the universe of records to be audited or reviewed. The sample size will be selected using accepted sample size estimation methods. The confidence level of the sample size calculation will not be less than 95 percent.

(2) Following the sample audit or review, the statistical margin of error of the sample will be computed, and a confidence interval will be determined. The estimated error rate will be extrapolated to the universe from which the sample was drawn within the computed margin of error of the sampling process.

(3) Commonly accepted statistical analysis programs may be used to estimate the sample size and calculate the confidence interval, consistent with the sampling parameters.

(4) The audit or review findings generated through statistical sampling procedures constitute prima facie evidence in all department proceedings regarding the number and amount of overpayments or underpayments received by the provider.

f. Self-audit. The department may require a provider to conduct a self-audit and report the results of the self-audit to the department.

79.4(4) *Preliminary report of audit or review findings.* If the department concludes from an audit or review that an overpayment has occurred, the department will issue a preliminary finding of a tentative overpayment and inform the provider of the opportunity to request a reevaluation.

79.4(5) *Disagreement with audit or review findings.* If a provider disagrees with the preliminary finding of a tentative overpayment, the provider may request a reevaluation by the department and may present clarifying information and supplemental documentation.

a. *Reevaluation request.* A request for reevaluation must be submitted in writing within 15 calendar days of the date of the notice of the preliminary finding of a tentative overpayment. The request must specify the issues of disagreement.

(1) If the audit or review is being performed by Iowa Medicaid, the request should be addressed to Iowa Medicaid at the department's address.

(2) If the audit or review is being performed by any other departmental entity, the request should be addressed to the department at its address.

b. *Additional information.* A provider that has made a reevaluation request pursuant to paragraph 79.4(5) "a" may submit clarifying information or supplemental documentation that was not previously provided. This information must be received at the applicable address within 30 calendar days of the mailing of the preliminary finding of a tentative overpayment to the provider, except as provided in paragraph "c" of this subrule.

c. *Disagreement with sampling results.* When the department's audit or review findings have been generated through sampling and extrapolation and the provider disagrees with the findings, the burden of proof of compliance rests with the provider. The provider may present evidence to show that the sample was invalid. The evidence may include a 100 percent audit or review of the universe of provider records used by the department in the drawing of the department's sample. Any such audit or review must:

(1) Be arranged and paid for by the provider.

(2) Be conducted by an individual or organization with expertise in coding, medical services, and Iowa Medicaid policy if the issues relate to clinical records.

(3) Be conducted by a certified public accountant if the issues relate to fiscal records.

(4) Demonstrate that bills and records that were not audited or reviewed in the department's sample are in compliance with program regulations.

(5) Be submitted to the department with all supporting documentation within 60 calendar days of the mailing of the preliminary finding of a tentative overpayment to the provider.

79.4(6) Finding and order for repayment. Upon completion of a requested reevaluation or upon expiration of the time to request reevaluation, the department will issue a finding and order for repayment of any overpayment and may immediately begin withholding payments on other claims to recover any overpayment.

79.4(7) Appeal by provider of care. A provider may appeal the finding and order of repayment and withholding of payments pursuant to 441—Chapter 2506. However, an appeal will not stay the withholding of payments or other action to collect the overpayment. Records not provided to the department during the review process set forth in subrule 79.4(3) or 79.4(5) are not admissible in any subsequent contested case proceeding arising out of a finding and order for repayment of any overpayment identified under subrule 79.4(6). This provision does not preclude providers that have provided records to the department during the review process set forth in subrule 79.4(3) or 79.4(5) from presenting clarifying information or supplemental documentation in the appeals process in order to defend against any overpayment identified under subrule 79.4(6). This provision is intended to minimize potential duplication of effort and delay in the audit or review process, minimize unnecessary appeals, and otherwise forestall fraud, waste, and abuse in the Iowa Medicaid program.

[ARC 0316D, IAB 5/27/26, effective 7/1/26]

441—79.5(249A) Nondiscrimination on the basis of handicap. All providers of service shall comply with Section 504 of the Rehabilitation Act of 1973 and federal regulations 45 CFR Part 84, both as amended to July 1, 2026, which prohibit discrimination on the basis of handicap in all federal Department of Health and Human Services funded programs.

[ARC 0316D, IAB 5/27/26, effective 7/1/26]

441—79.6(249A) Provider participation agreement. Providers of medical and health care wishing to participate in the program shall execute an agreement with the department on an Agreement Between Provider of Medical and Health Services and the Iowa Department of Health and Human Services Regarding Participation in Medical Assistance Program.

EXCEPTION: Dental providers are required to complete an Addendum to Dental Provider Agreement for Orthodontia to receive reimbursement under the early and periodic screening, diagnosis, and treatment program.

In these agreements, the provider agrees to the following:

79.6(1) To maintain clinical and fiscal records as specified in rule 441—79.3(249A).

79.6(2) That the charges as determined in accordance with the department's policy shall be the full and complete charge for the services provided and no additional payment shall be claimed from the recipient or any other person for services provided under the program.

79.6(3) That it is understood that payment in satisfaction of the claim will be from federal and state funds and any false claims, statements, or documents, or concealment of a material fact may be prosecuted under applicable federal and state laws.

[ARC 0316D, IAB 5/27/26, effective 7/1/26]

441—79.7(249A) Medicaid advisory council.

79.7(1) Officers.

a. The public co-chairperson's term of office shall be two years. A public co-chairperson shall serve no more than two consecutive terms.

b. The public co-chairperson shall have the right to vote on any issue before the council.

c. The position of public co-chairperson shall be held by one of the five public council members. Ballots will be distributed to the public council members at the quarterly meeting closest to the beginning of the next state fiscal year and will be collected in paper and electronic format and administered by the department. The initial ballot will be distributed by email prior to the first meeting in that fiscal year in order to identify the public co-chairperson prior to the council's first meeting.

d. Responsibilities.

(1) The co-chairpersons shall be responsible for development of the agendas for meetings of the council. Agendas will be developed and distributed in compliance with the advance notice requirements of Iowa Code section 21.4. Agendas will be developed in consultation with department staff and the director, taking into consideration the following:

1. Work plans. Items will be added to the council's agenda as various tasks for the council are due to be discussed based on calendar requirements. Council deliberations are to be conducted within a time frame to allow the council to receive and make recommendations to the director and for the director to consider those recommendations as budgets and policy for the medical assistance program are developed for the review of the council on human services and the governor, as well as for the upcoming legislative session.

2. Requests from the director.

3. Discussion and action items from council members. The co-chairpersons will review any additional suggestions from council members at any time, including after the draft agenda has been distributed. The agenda will be distributed in draft form five business days prior to the council meeting, and the final agenda will be distributed no later than 24 hours prior to the council meeting.

(2) The co-chairpersons shall preside over all council meetings, calling roll, determining a quorum, counting votes, and following the agenda for the meeting.

(3) The co-chairpersons shall consult with the department on other administrative tasks to oversee the council and shall participate in workgroups and subcommittees as appropriate.

79.7(2) *Membership.* The membership of the council shall be as prescribed in Iowa Code section 249A.4B.

a. Council membership of professional and business entities shall number five and be identified from a vote among those entities outlined in Iowa Code section 249A.4B(3). Professional and business entities shall vote every fiscal year to identify the entities and their subsequent representatives that will represent the body of professional and business stakeholders on the council. Professional and business entities will also report their contact information to the department.

(1) The length of term for all following elected members shall be two years.

(2) Elections shall be organized along the following guidelines.

1. Ballots will be distributed at the quarterly meeting closest to the beginning of the next state fiscal year and will be collected in paper and electronic format and counted by department staff.

2. The entities that receive the most votes shall serve on the council.

(3) Should any vacancy occur on the council, the entity that received the next highest number of votes in the most recent election shall serve on the council.

(4) If a voting entity's representative does not attend more than three consecutive meetings, the department will notify the entity and representative and verify whether an alternative contact is needed. If a fourth consecutive meeting is missed after the notification, the voting entity's seat will be considered vacant and will be filled as outlined in subparagraph 79.7(2) "a"(3).

b. Council membership of public representatives shall consist of five representatives, of whom one must be a recipient of medical assistance. All five public representatives will be appointed by the governor for staggered terms of two years each. All five public representatives will be voting members of the council.

c. Reserved.

d. Council membership shall also consist of state agency and medical school partners, including representatives from Des Moines University Medicine and Health Sciences and the University of Iowa Carver College of Medicine.

(1) Partner agency and medical school representatives will be nonvoting members of the council.

(2) If an agency's or school's representative does not attend more than three consecutive meetings, the department will notify the agency or school.

(3) Partner agencies and medical schools shall determine the length of appointment of their representatives. The department will confirm each representative's participation every two years.

e. The following members of the general assembly shall be members of the council, each for a term of two years as provided in Iowa Code section 4A.13. Members appointed from the general assembly will serve as nonvoting members of the council.

(1) Two members of the house of representatives, one appointed by the speaker of the house of representatives and one appointed by the minority leader of the house of representatives from their respective parties.

(2) Two members of the senate, one appointed by the president of the senate after consultation with the majority leader of the senate and one appointed by the minority leader of the senate from their respective parties.

79.7(3) *Responsibilities, duties and meetings.* The responsibility of the medical assistance advisory council is to provide recommendations on the medical assistance program to the department.

a. Recommendations. Recommendations made by the council shall be advisory and not binding upon the department or the professional and business entities represented. The director will consider the recommendations in the director's preparation of medical assistance budget recommendations to the council on human services pursuant to Iowa Code section 217.3 and implementation of medical assistance program policies.

b. Council. The council shall be provided with information to deliberate and provide input on the medical assistance program. The council will use that input in making final recommendations to the department.

(1) Council meetings.

1. The council will meet quarterly at a minimum.

2. Meetings may be called by the co-chairpersons; upon written request of at least 50 percent of members; or by the director.

3. Meetings shall be held in the Des Moines, Iowa, area unless other notification is given. Meetings will also be made available via teleconference, when available.

4. Written notice of council meetings shall be electronically mailed at least five business days in advance of the meeting. Each notice shall include an agenda for the meeting. The final agenda will be distributed no later than 24 hours prior to the meeting.

(2) The council shall advise the professional and business entities represented and act as liaison between them and the department.

(3) The council shall perform other functions as may be provided by state or federal law or regulation.

(4) Pursuant to 2016 Iowa Acts, chapter 1139, section 93, the council shall regularly review Medicaid managed care. The council shall submit an executive summary of pertinent information regarding deliberations during the prior year relating to Medicaid managed care to the department no later than November 15 annually.

(5) Pursuant to 2016 Iowa Acts, chapter 1139, section 94, the council shall submit to the chairpersons and ranking members of the human resources committees of the senate and house of representatives and to the chairpersons and ranking members of the joint appropriations subcommittee on health and human services, on a quarterly basis, minutes of the council meetings during which the council addressed Medicaid managed care.

79.7(4) *Procedures.*

a. A quorum shall consist of 50 percent (five persons) of the current voting members.

b. Where a quorum is present, a position is carried by two-thirds of the present council members.

c. Minutes of council meetings and other written materials developed by the council shall be distributed by the department to each member of the council.

d. In cases not covered by these rules, Robert's Rules of Order shall govern.

79.7(5) *Expenses, staff support, and technical assistance.* Expenses of the council, such as those for clerical services, mailing, telephone, and meeting place, shall be the responsibility of the

department. The department will arrange for a meeting place, related services, and accommodations. The department will provide staff support and independent technical assistance to the council.

a. The department will provide reports, data, and proposed and final amendments to rules, laws, and guidelines to the council for its information, review, and comment.

b. The department will present the annual budget for the medical assistance program for review and comment.

c. The department will permit staff members to appear before the council to review and discuss specific information and problems.

d. The department will maintain a current list of members on the council.

e. The department will be responsible for the organization of all council meetings and notice of meetings.

f. As required in Iowa Code section 21.3, minutes of the meetings of the council will be kept by the department. The council will review minutes before distribution to the public.

[ARC 0316D, IAB 5/27/26, effective 7/1/26]

441—79.8(249A) Beneficiary advisory council. Pursuant to 42 CFR 431.12(e), Iowa Medicaid will form and support a beneficiary advisory council. The council will be governed by bylaws, which are available on the department's website.

[ARC 0316D, IAB 5/27/26, effective 7/1/26]

441—79.9(249A) Requests for prior authorization. This rule governs requests for prior authorization for services not provided through an MCO. For services provided through an MCO, the prior authorization request is submitted, reviewed, and authorized by the MCO.

79.9(1) Making the request.

a. Providers may submit requests for prior authorization for any items or procedures, other than prescription drugs, by mail or by facsimile transmission (fax) using an Outpatient Prior Authorization Request form, or electronically using the Accredited Standards Committee (ASC) X12N 278 transaction, Health Care Services Request for Review and Response. Requests for prior authorization for drugs must be submitted on any Request for Prior Authorization form designated for the drug being requested in the preferred drug list published pursuant to Iowa Code chapter 249A.

b. Providers shall send requests for prior authorization to Iowa Medicaid. The request should address the relevant criteria applicable to the particular service, medication or equipment for which prior authorization is sought according to rule 441—78.28(249A). Copies of history and examination results may be attached to rather than incorporated in the letter.

c. If a request for prior authorization submitted electronically requires attachments or supporting clinical documentation and a national electronic attachment has not been adopted, the provider shall:

(1) Use a Prior Authorization Attachment Control form as the cover sheet for the paper attachments or supporting clinical documentation; and

(2) Reference on that form the attachment control number submitted on the ASC X12N 278 electronic transaction.

79.9(2) The policy applies to services or items specifically designated as requiring prior authorization.

79.9(3) The provider shall receive a notice of approval or denial for all requests.

a. In the case of prescription drugs, notices of approval or denial will be faxed to the prescriber and pharmacy.

b. Decisions regarding approval or denial of prescription drugs will be made within 24 hours from the receipt of the prior authorization request. In cases where the request is received during nonworking hours, the time limit will be construed to start with the first hour of the normal working day following the receipt of the request.

c. Decisions regarding approval or denial for items or procedures other than prescription drugs will be made according to the time frames set forth in 42 CFR 438.210(d) as amended to July 1, 2026.

79.9(4) Prior authorizations approved because a decision is not timely made shall not be considered a precedent for future similar requests.

79.9(5) Approved prior authorization applies to covered services and does not apply to the recipient's eligibility for medical assistance.

79.9(6) If a provider is unsure if an item or service is covered because it is rare or unusual, the provider may submit a request for prior approval in the same manner as other requests for prior approval in subrule 79.9(1).

79.9(7) Requests for prior approval of services will be reviewed according to rule 441—79.9(249A) and the conditions for payment as established by rule in 441—Chapter 78.

a. Where ambiguity exists as to whether a particular item or service is covered, requests for prior approval will be reviewed according to the following criteria in order of priority:

(1) The conditions for payment outlined in the provider manual with reference to coverage and duration.

(2) The determination made by the Medicare program unless specifically stated differently in state law or rule.

(3) The recommendation to the department from the appropriate advisory committee.

(4) Whether there are other less expensive covered procedures that would be as effective.

(5) The advice of an appropriate professional consultant.

b. When Iowa Medicaid has not reached a decision on a request for prior authorization after 60 days from the date of receipt, the request will be approved.

79.9(8) The amount, duration and scope of the Medicaid program is outlined in 441—Chapters 78, 79, 81, 82 and 85. Additional clarification of policies is available in the provider manual distributed and updated to all participating providers.

79.9(9) Iowa Medicaid will issue a notice of decision to the recipient upon a denial of request for prior approval pursuant to 441—Chapter 16. Iowa Medicaid will mail the notice of decision to the recipient within five working days of the date the prior approval form is returned to the provider.

79.9(10) If a request for prior approval is denied by Iowa Medicaid, the request may be resubmitted for reconsideration with additional information justifying the request. The aggrieved party may file an appeal in accordance with 441—Chapter 2506.

[ARC 0316D, IAB 5/27/26, effective 7/1/26]

441—79.10(249A) General provisions for Medicaid coverage applicable to all Medicaid providers and services.

79.10(1) Medicare definitions and policies apply to services provided unless specifically defined differently.

79.10(2) The services covered by Medicaid shall:

a. Be consistent with the diagnosis and treatment of the patient's condition.

b. Be in accordance with standards of good medical practice.

c. Be required to meet the medical need of the patient and be for reasons other than the convenience of the patient or the patient's practitioner or caregiver.

d. Be the least costly type of service that would reasonably meet the medical need of the patient.

e. Be eligible for federal financial participation unless specifically covered by state law or rule.

f. Be within the scope of the licensure of the provider.

g. Be provided with the full knowledge and consent of the recipient or someone acting in the recipient's behalf unless otherwise required by law or court order or in emergency situations.

h. Be supplied by a provider who is eligible to participate in the Medicaid program. The provider must use the billing procedures and documentation requirements described in 441—Chapters 78 and 80.

79.10(3) Providers shall supply all the same services to Medicaid eligibles served by the provider as are offered to other clients of the provider.

79.10(4) Recipients must be informed before the service is provided that the recipient will be responsible for the bill if a noncovered service is provided.

79.10(5) Medical services provided to a person while the person is an inmate of a public jail, prison, juvenile detention center, or other public penal institution of more than four beds are not covered by Medicaid.

79.10(6) The acceptance of Medicaid funds by means of a prospective or interim rate creates an express trust. The Medicaid funds received constitute the trust res. The trust terminates when the rate is retrospectively adjusted or otherwise finalized and, if applicable, any Medicaid funds determined to be owed are repaid in full to the department.

79.10(7) Incorrect payment.

a. Except as provided in paragraph 79.10(7) “*b*,” medical assistance funds are incorrectly paid whenever an individual who provided the service to the member for which the department paid was at the time service was provided the parent of a minor child, spouse, or legal representative of the member.

b. Notwithstanding paragraph 79.10(7) “*a*,” medical assistance funds are not incorrectly paid when an individual who serves as a member’s legal representative provides services to the member under a home- and community-based services waiver attendant care agreement or under a consumer choices option employment agreement in effect on or after December 31, 2013. For purposes of this paragraph, “legal representative” means a person, including an attorney, who is authorized by law to act on behalf of the medical assistance program member but does not include the spouse of a member or the parent or stepparent of a member aged 17 or younger.

79.10(8) The rules of the medical assistance program shall not be construed to require payment of medical assistance funds, in whole or in part, directly or indirectly, overtly or covertly, for the provision of non-Medicaid services. The rules of the medical assistance program shall be interpreted in such a manner to minimize any risk that medical assistance funds might be used to subsidize services to persons other than members of the medical assistance program.

[ARC 0316D, IAB 5/27/26, effective 7/1/26]

441—79.11(249A) Requests for preadmission review. The inpatient hospitalization of Medicaid recipients is subject to preadmission review by Iowa Medicaid as required in rule 441—78.3(249A).

79.11(1) The patient’s admitting physician, the physician’s designee, or the hospital will contact Iowa Medicaid to request approval of Medicaid coverage for the hospitalization according to instructions issued to providers by Iowa Medicaid and instructions in the Medicaid provider manual.

79.11(2) Medicaid payment will not be made to the hospital if Iowa Medicaid denies the procedure requested in the preadmission review.

79.11(3) Iowa Medicaid will issue a letter of denial to the patient, the physician, and the hospital when a request is denied. The patient, the physician, or the hospital may request a reconsideration of the decision by filing a written request with Iowa Medicaid within 60 days of the date of the denial letter.

79.11(4) The aggrieved party may appeal a denial of a request for reconsideration by Iowa Medicaid according to 441—Chapter 2506.

79.11(5) The requirement to obtain preadmission review is waived when the patient is enrolled in the managed health care option known as patient management and proper authorization for the admission has been obtained from the patient manager as described in 441—Chapter 73.

[ARC 0316D, IAB 5/27/26, effective 7/1/26]

441—79.12(249A) Requests for preprocedure surgical review. Iowa Medicaid conducts a preprocedure review of certain frequently performed surgical procedures to determine the necessity of the procedures and if Medicaid payment will be approved according to requirements found in 441—subrules 78.1(19), 78.3(18), and 78.26(3).

79.12(1) The physician must request approval from Iowa Medicaid when the physician expects to perform a surgical procedure appearing on the department’s preprocedure surgical review list

published in the Medicaid provider manual. All requests for preprocedure surgical review shall be made according to instructions issued to physicians, hospitals and ambulatory surgical centers appearing in the Medicaid provider manual and instructions issued to providers by Iowa Medicaid.

79.12(2) Iowa Medicaid will issue the physician a validation number for each request and advise whether payment for the procedure will be approved or denied.

79.12(3) Iowa Medicaid payment will not be made to the physician and other medical personnel or the facility in which the procedure is performed, e.g., hospital or ambulatory surgical center, if Iowa Medicaid does not give approval.

79.12(4) Iowa Medicaid will issue a denial letter to the patient, the physician, and the facility when the requested procedure is not approved. The patient, the physician, or the facility may request a reconsideration of the decision by filing a written request with Iowa Medicaid within 60 days of the date of the denial letter.

79.12(5) The aggrieved party may appeal a denial of a request for reconsideration by Iowa Medicaid in accordance with 441—Chapter 2506.

[ARC 0316D, IAB 5/27/26, effective 7/1/26]

441—79.13(249A) Advance directives. “Advance directive” means a written instruction, such as a living will or durable power of attorney for health care, recognized under state law and related to the provision of health care when the person is incapacitated. All hospitals, home health agencies, home health providers of waiver services, hospice programs, and health maintenance organizations (HMOs) participating in Medicaid shall establish policies and procedures with respect to all adults receiving medical care through the provider or organization to comply with state law regarding advance directives as follows:

79.13(1) A hospital at the time of a person’s admission as an inpatient, a home health care provider in advance of a person’s coming under the care of the provider, a hospice provider at the time of initial receipt of hospice care by a person, and an HMO at the time of enrollment of the person with the organization shall provide written information to each adult that explains the person’s rights under state law to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives, and the provider’s policies regarding the implementation of these rights.

79.13(2) The provider or organization shall document in the person’s medical record whether or not the person has executed an advance directive.

79.13(3) The provider or organization shall not condition the provision of care or otherwise discriminate against a person based on whether or not the person has executed an advance directive.

79.13(4) The provider or organization shall ensure compliance with requirements of state law regarding advance directives.

79.13(5) The provider or organization shall provide for education for staff and the community on issues concerning advance directives.

Nothing in this rule shall be construed to prohibit the application of a state law that allows for an objection on the basis of conscience for any provider or organization that as a matter of conscience cannot implement an advance directive.

[ARC 0316D, IAB 5/27/26, effective 7/1/26]

441—79.14(249A) Requirements for enrolled Medicaid providers supplying laboratory services. Medicaid-enrolled entities providing laboratory services are subject to the provisions of the Clinical Laboratory Improvement Amendments of 1988 (CLIA) and Public Law 100-578, both as amended to July 1, 2026, and implementing federal regulations published at 42 CFR Part 493 as amended to July 1, 2026. Medicaid payment will not be afforded for services provided by an enrolled Medicaid provider supplying laboratory services that fails to meet these requirements. For the purposes of this rule, laboratory services are defined as services to examine human specimens for the diagnosis, prevention or treatment of any disease or impairment of, or assessment of, the health of human beings.

[ARC 0316D, IAB 5/27/26, effective 7/1/26]

441—79.15(249A) Provider enrollment.

79.15(1) Application request. Iowa Medicaid providers, including those enrolled with an MCO, shall begin the enrollment process by completing the appropriate application on the department's website. Managed care organizations and fiscal agents are exempt from completing an application.

a. Providers of home- and community-based waiver services shall submit a Medicaid HCBS Provider Application form at least 90 days before the planned service implementation date.

b. Providers enrolling as ordering or referring providers shall submit an Iowa Medicaid Ordering/Referring Provider Enrollment Application form.

c. All other providers shall submit an Iowa Medicaid Provider Enrollment Application form.

d. A nursing facility shall also complete the process set forth in 441—subrule 81.11(1).

e. An intermediate care facility for persons with an intellectual disability shall also complete the process set forth in rule 441—82.3(249A).

f. Qualified Medicare beneficiary (QMB) providers shall enroll using a Qualified Medicare Beneficiaries (QMB) or Health Insurance Premium Payment (HIPP) Program Provider Enrollment Application form.

g. Health insurance premium payment (HIPP) providers shall enroll using a Qualified Medicare Beneficiaries (QMB) or Health Insurance Premium Payment (HIPP) Program Provider Enrollment Application form.

79.15(2) Submittal of application. The provider shall submit the appropriate application forms, including the application fee, if required, to Iowa Medicaid at the department's address.

a. The application shall include the provider's national provider identifier number or shall indicate that the provider is an atypical provider that is not issued a national provider identifier number.

b. With the application form, an assertive community treatment program shall submit an Assertive Community Services (ACS) Provider Agreement Addendum and agree to file with the department an annual report containing information to be used for rate setting, including:

(1) Data by practitioner on the utilization by Medicaid members of all the services included in assertive community treatment, and

(2) Cost information by practitioner type and by type of service actually delivered as part of assertive community treatment.

c. Reserved.

d. Application fees.

(1) Providers who are enrolling or reenrolling in the Iowa Medicaid program shall submit an application fee with their application unless they are exempt as set forth in this paragraph.

(2) Fee amount. The application fee shall be in the amount prescribed by the Secretary of the U.S. Department of Health and Human Services (the Secretary) for the calendar year in which the application is submitted and in accordance with 42 U.S.C. 1395cc(j)(2)(C) as amended to July 1, 2026.

(3) Nonrefundable. The application fee is nonrefundable, except if submitted with one of the following:

1. A hardship exception request that is subsequently approved by the Secretary.

2. An application that is subsequently denied as a result of a temporary moratorium under Iowa Code section 249A.48.

3. An application or other transaction in which the application fee is not required.

(4) The process for enrolling or reenrolling a provider will not begin until the application fee has been received by the department or a hardship exception request has been approved by the Secretary.

(5) The following providers shall not be required to submit an application fee:

1. Individual physicians or nonphysician practitioners.

2. Providers that are enrolled in Medicare, another state's Medicaid program or another state's children's health insurance program.

3. Providers that have paid the applicable application fee within 12 months of the date of application submission to a Medicare contractor or another state.

(6) All application fees collected shall be used for the costs associated with the screening procedures as described in subrule 79.15(4). Any unused portion of the application fees collected shall be returned to the federal government in accordance with 42 CFR §455.460 as amended to July 1, 2026.

79.15(3) Program integrity information requirements.

a. All providers, including but not limited to MCOs and Medicaid fiscal agents, applying for participation in the Iowa Medicaid program must disclose all information required to be submitted pursuant to 42 CFR Part 455 as amended to July 1, 2026. In addition, all providers shall disclose any current, or previous, direct or indirect affiliation with a present or former Iowa Medicaid provider that:

(1) Has any uncollected debt owed to Medicaid or any other health care program funded by any governmental entity, including but not limited to the federal and state of Iowa governments;

(2) Has been or is subject to a payment suspension under a federally funded health care program;

(3) Has been excluded from participation under Medicaid, Medicare, or any other federally funded health care program;

(4) Has had its billing privileges denied or revoked;

(5) Has been administratively dissolved by the Iowa secretary of state, or similar action has been taken by a comparable agency in another state; or

(6) Shares a national provider identification (NPI) number or tax ID number with another provider that meets the criteria specified in subparagraph 79.15(3)“*a*”(1), “*a*”(2), “*a*”(3), “*a*”(4), or “*a*”(5).

b. Iowa Medicaid may deny enrollment to a provider applicant or disenroll a current provider that has any affiliation as set forth in this rule if the department determines that the affiliation poses a risk of fraud, waste, or abuse. Such denial or disenrollment is appealable under 441—Chapter 2506, but, notwithstanding any provision to the contrary in that chapter, the provider shall bear the burden to prove by clear and convincing evidence that the affiliation does not pose any risk of fraud, waste, or abuse. Iowa Medicaid will deny enrollment to or immediately disenroll any person that Iowa Medicaid, Medicare, or any other state Medicaid program has ever terminated under rule 441—79.2(249A) or a similar provision and will deny enrollment to any person presently suspended from participation, or who would be subject to a suspension, under paragraph 79.2(3)“*c*.” Further, a person sanctioned under rule 441—79.2(249A) or a similar provision may not manage consumer choices option (CCO) funds for a member.

c. For purposes of this rule, the term “direct or indirect affiliation” includes but is not limited to relationships between individuals, business entities, or a combination of the two. The term includes but is not limited to direct or indirect business relationships that involve:

(1) A compensation arrangement;

(2) An ownership arrangement;

(3) Managerial authority over any member of the affiliation;

(4) The ability of one member of the affiliation to control or influence any other; or

(5) The ability of a third party to control or influence any member of the affiliation.

d. Notwithstanding any previous successful enrollment in the medical assistance program, the passing of any background check by the department or any other entity, or similar prior approval for participation as a provider in the medical assistance program, in whole or in part, disenrollment from the medical assistance program is mandatory when, in the case of a corporation or similar entity, 5 percent or more of the corporation or similar entity is owned, controlled, or directed by a person who (1) has within the last five years been listed on any dependent adult abuse registry, child abuse registry, or sex offender registry; (2) has pled guilty or nolo contendere to, or was convicted of, any crime punishable by a term of imprisonment greater than five years; (3) has, within the last five years, pled guilty or nolo contendere to, or was convicted of, any controlled substance offense; (4) has, within the last ten years, pled guilty or nolo contendere to, or was convicted of, any crime involving

an allegation of dishonesty punishable by a term of imprisonment greater than one year but not more than five years; or (5) within the last ten years, has on more than one occasion pled guilty or nolo contendere to, or was convicted of, any crime involving an allegation of dishonesty.

79.15(4) Screening procedures and requirements. Providers applying for participation in the Iowa Medicaid program shall be subject to the “limited,” “moderate,” or “high” categorical risk screening procedures and requirements in accordance with 42 CFR §455.450 as amended to July 1, 2026.

a. For the types of providers that are recognized as a provider under the Medicare program, Iowa Medicaid will use the same categorical risk screening procedures and requirements assigned to that provider type by Medicare pursuant to 42 CFR §424.518 as amended to July 1, 2026.

b. Provider types not assigned a screening level by the Medicare program will be subject to the procedures of the “limited” risk screening level pursuant to 42 CFR §455.450 as amended to July 1, 2026.

c. Adjustment of risk level. Iowa Medicaid will adjust the categorical risk screening procedures and requirements from “limited” or “moderate” to “high” when any of the following occurs:

(1) Iowa Medicaid imposes a payment suspension on a provider based on a credible allegation of fraud, waste, or abuse; the provider has an existing Medicaid overpayment; or within the previous ten years, the provider has been excluded by the Office of the Inspector General or another state’s Medicaid program; or

(2) Iowa Medicaid or CMS in the previous six months lifted a temporary moratorium for the particular provider type, and a provider that was prevented from enrolling based on the moratorium applies for enrollment as a provider at any time within six months from the date the moratorium was lifted.

79.15(5) Notification. A provider will be notified of the decision on the provider’s application within 30 calendar days of receipt by Iowa Medicaid of a complete and correct application with all required documents, including but not limited to, if applicable, any application fees or screening results.

79.15(6) A provider that is not approved as the Medicaid provider type requested shall have the right to appeal under 441—Chapter 2506.

79.15(7) Effective date of approval. An application shall be approved retroactive to the date requested by the provider or the date the provider meets the applicable participation criteria, whichever is later, not to exceed 12 months retroactive from the receipt of the application with all required documents by Iowa Medicaid.

79.15(8) A provider approved for certification as a Medicaid provider shall complete a provider participation agreement as required by rule 441—79.6(249A).

79.15(9) No payment will be made to a provider for care or services provided prior to the effective date of Iowa Medicaid’s approval of an application.

79.15(10) Payment rates dependent on the nature of the provider or the nature of the care or services provided will be based on information on the application, together with information on claim forms, or on rates paid the provider prior to April 1, 1993.

79.15(11) An amendment to an application shall be submitted to Iowa Medicaid and will be approved or denied within 30 calendar days. Approval of an amendment will be retroactive to the date requested by the provider or the date the provider meets all applicable criteria, whichever is later, not to exceed 30 days prior to the receipt of the amendment by Iowa Medicaid. Denial of an amendment may be appealed under 441—Chapter 2506.

79.15(12) A provider that has not submitted a claim in the last 24 months will be sent a notice asking if the provider wishes to continue participation. A provider that fails to reply to the notice within 30 calendar days of the date on the notice will be terminated as a provider. Providers that do not submit any claims in 48 months will be terminated as providers without further notification.

79.15(13) Report of changes. The provider shall inform Iowa Medicaid of all pertinent changes to enrollment information within 35 days of the change. Pertinent changes include but are not limited

to changes to the business entity name, individual provider name, tax identification number, mailing address, telephone number, or any information required to be disclosed by subrule 79.15(3).

a. When a provider reports false, incomplete, or misleading information on any application or reapplication, or fails to provide current information within the 35-day period, Iowa Medicaid may immediately terminate the provider's Medicaid enrollment. The termination may be appealed under 441—Chapter 2506. Such termination remains in effect notwithstanding any pending appeal.

b. When the department incurs an informational tax-reporting fine or is required to repay the federal share of medical assistance paid to the provider because a provider submitted inaccurate information or failed to submit changes to Iowa Medicaid in a timely manner, the fine or repayment shall be the responsibility of the individual provider to the extent that the fine or repayment relates to or arises out of the provider's failure to keep all provider information current.

(1) The provider shall remit the amount of the fine or repayment to the department within 30 days of notification by the department that the fine has been imposed.

(2) Payment of the fine or repayment may be appealed under 441—Chapter 2506.

79.15(14) Provider termination or denial of enrollment. Iowa Medicaid must terminate or deny any provider enrollment when the provider has violated any requirements identified in 42 CFR §455.416 as amended to July 1, 2026.

79.15(15) Temporary moratoria. Iowa Medicaid must impose any temporary moratorium pursuant to Iowa Code section 249A.48.

79.15(16) Provider revalidation. Providers are required to complete the application process and screening requirements as detailed in this rule every five years.

79.15(17) Recoupment. A provider is strictly liable for any failure to disclose the information required by subrule 79.15(3) or any failure to report a change required by subrule 79.15(13). The department shall recoup as incorrectly paid all funds paid to the provider before a complete disclosure or report of change was made. The department shall also recoup as incorrectly paid all funds to any provider that billed Iowa Medicaid while the provider was administratively dissolved by the Iowa secretary of state or comparable agency of another state, even if the provider subsequently obtains a retroactive reinstatement from the Iowa secretary of state or similar action was taken against the provider by a comparable agency of another state.

[ARC 0316D, IAB 5/27/26, effective 7/1/26]

441—79.16(249A) Education about false claims recovery. The provisions in this rule apply to any entity that has received medical assistance payments totaling at least \$5 million during a federal fiscal year (ending on September 30). For entities whose payments reach this threshold, compliance with this rule is a condition of receiving payments under the medical assistance program during the following calendar year.

79.16(1) *Policy requirements.* Any entity whose medical assistance payments meet the threshold shall:

a. Establish written policies for all employees of the entity and for all employees of any contractor or agent of the entity, including management, that provide detailed information about:

(1) The False Claims Act established under 31 U.S.C. Sections 3729 through 3733 as amended to July 1, 2026;

(2) Administrative remedies for false claims and statements established under 31 U.S.C. Chapter 38 as amended to July 1, 2026;

(3) Any state laws pertaining to civil or criminal penalties for false claims and statements;

(4) Whistle blower protections under the laws described in subparagraphs 79.16(1)“a”(1) through “a”(3) with respect to the role of these laws in preventing and detecting fraud, waste, and abuse in federal health care programs as defined in 42 U.S.C. Section 1320a-7b(f) as amended to July 1, 2026; and

(5) The entity's policies and procedures for detecting and preventing fraud, waste, and abuse.

b. Include in any employee handbook a specific discussion of:

- (1) The laws described in paragraph 79.16(1) “a”;
- (2) The rights of employees to be protected as whistle blowers; and
- (3) The entity’s policies and procedures for detecting and preventing fraud, waste, and abuse.

79.16(2) *Reporting requirements.*

a. Any entity whose medical assistance payments meet the specified threshold during a federal fiscal year shall provide the following information to Iowa Medicaid by the following December 31:

- (1) The name, address, and national provider identification numbers under which the entity receives payment;
- (2) Copies of written or electronic policies that meet the requirements of subrule 79.16(1); and
- (3) A written description of how the policies are made available and disseminated to all employees of the entity and to all employees of any contractor or agent of the entity.

b. The information may be provided by:

- (1) Mailing the information to Iowa Medicaid at the department’s address; or
- (2) Faxing the information to 515.725.1354.

79.16(3) *Enforcement.* Any entity that fails to comply with the requirements of this rule shall be subject to sanction under rule 441—79.2(249A), including probation, suspension or withholding of payments, and suspension or termination from participation in the medical assistance program.

This rule is intended to implement Iowa Code section 249A.4 and Public Law 109-171, Section 6032, as amended to July 1, 2026.

[ARC 0316D, IAB 5/27/26, effective 7/1/26]

441—79.17(249A) Requirements for prescribing controlled substances.

79.17(1) *Review of Iowa prescription monitoring program database.* A prescribing practitioner, as defined in Iowa Code section 124.550, or the prescribing practitioner’s designated agent, shall review patient information in the Iowa prescription monitoring program (PMP) database prior to issuing a prescription for a controlled substance as defined in 42 U.S.C. 1396w-3a, inclusive of Schedules II, III and IV as amended to July 1, 2026, unless the patient is receiving inpatient hospice care or long-term residential facility care. Review shall be conducted in accordance with all requirements under the prescribing practitioner’s specific professional licensing authority.

79.17(2) *Documentation.* The prescribing practitioner shall include documentation in the patient file to demonstrate compliance with subrule 79.17(1). Subject to the requirements under Iowa Code chapter 124, subchapter VI, if the prescribing practitioner is not able to conduct a review of the PMP database despite a good-faith effort, the prescribing practitioner must document in the patient file such good-faith effort, including the reasons why the prescribing practitioner was not able to conduct the review. The prescribing practitioner shall submit such documentation to Iowa Medicaid upon request.

This rule is intended to implement Iowa Code chapters 124 and 249A.

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These rules are intended to implement Iowa Code chapter 249A.

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◇ Two or more ARCs

1 Effective date of 79.1(2) and 79.1(5) "t" delayed 70 days by the Administrative Rules Review Committee at its January 1988, meeting.
 2 Effective date of 4/1/90 delayed 70 days by the Administrative Rules Review Committee at its March 12, 1990, meeting; delay lifted by this Committee, effective May 11, 1990.
 3 Effective date of subrule 79.1(13) delayed until adjournment of the 1992 Sessions of the General Assembly by the Administrative Rules Review Committee at its meeting held July 12, 1991.
 4 Effective date of 3/1/92 delayed until adjournment of the 1992 General Assembly by the Administrative Rules Review Committee at its meeting held February 3, 1992.

- ⁵ At a special meeting held January 24, 2002, the Administrative Rules Review Committee voted to delay until adjournment of the 2002 Session of the General Assembly the effective date of amendments published in the February 6, 2002, Iowa Administrative Bulletin as **ARC 1365B**.
- ⁶ Effective date of October 1, 2002, delayed 70 days by the Administrative Rules Review Committee at its meeting held September 10, 2002. At its meeting held November 19, 2002, the Committee voted to delay the effective date until adjournment of the 2003 Session of the General Assembly.
- ⁷ July 1, 2009, effective date of amendments to 79.1(1)“d,” 79.1(2), and 79.1(24)“a”(1) delayed 70 days by the Administrative Rules Review Committee at a special meeting held June 25, 2009.
- ⁸ See HJR 2008 of 2012 Session of the Eighty-fourth General Assembly regarding nullification of amendment to 79.1(7)“b” (ARC 9959B, IAB 1/11/12).
- ⁹ July 1, 2019, effective date of **ARC 4430C** [amendments to chs 78, 79] delayed until the adjournment of the 2020 session of the General Assembly by the Administrative Rules Review Committee at its meeting held June 11, 2019; delay lifted at the meeting held September 10, 2019.
- ¹⁰ March 18, 2020, effective date of **ARC 4899C** [amendments to chs 78, 79] delayed until the adjournment of the 2021 session of the General Assembly by the Administrative Rules Review Committee at its meeting held March 6, 2020; delay lifted at the meeting held August 11, 2020.

CHAPTER 80
PROCEDURE AND METHOD OF PAYMENT
[Prior to 7/1/83, Social Services[770] Ch 80]

Chapter rescission date pursuant to Iowa Code section 17A.7: 7/1/31

441—80.1(249A) Submission of claims. Providers of medical and remedial care participating in the program shall submit claims for services rendered to Iowa Medicaid on at least a monthly basis. All nursing facilities and providers of home- and community-based services shall submit claims for services after the end of the calendar month in which the services are provided. Following audit of the claim, Iowa Medicaid will make payment to the provider of care. The provider manual, Chapter IV, Billing Iowa Medicaid, found on the department's website and as amended to July 1, 2026, will detail the specific manner and frequency in which claims are to be submitted.

80.1(1) Electronic submission. Providers are required to submit claims electronically whenever possible.

80.1(2) For fee-for-service members, providers billing claims for Medicare beneficiaries that do not cross over electronically to Iowa Medicaid must submit the following electronically, in accordance with the All Providers manual, Chapter IV, Billing Iowa Medicaid, located on the department's website and as amended to July 1, 2026:

a. Form UB-04.

b. Form CMS-1500. The Explanation of Medicare Benefits (EOMB) is only required when requested by Iowa Medicaid.

[ARC 0317D, IAB 5/27/26, effective 7/1/26]

441—80.2(249A) Payment from other sources. This rule applies to claims for the department, managed care organizations, and the Public Health Associate Program (PHAP).

80.2(1) *Payments deducted.* The amount of any payment made directly to the provider of care by the recipient, relatives, or any source will be deducted from the established cost standard for the service provided to establish the amount of payment to be made by Iowa Medicaid.

80.2(2) *Third-party liability.*

a. When a third-party liability for medical expenses exists, this resource will be utilized for payment of a claim before the Medicaid program makes payment unless:

(1) The department pays the total amount allowed under the Medicaid payment schedule and then seeks reimbursement from the liable third party. This "pay and chase" provision applies to claims for:

1. Preventive pediatric services, and

2. All services provided to a person for whom there is court-ordered medical support.

(2) Otherwise authorized by the department.

b. All claims must be clean claims. A clean claim is defined as a claim that has no defect or impropriety (including any lack of required substantiating documentation) or particular circumstance requiring special treatment that prevents timely payment of the claim.

80.2(3) *Recovery from third parties legally responsible to pay for health care.* Parties that are, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service shall:

a. No later than 60 days after receiving any inquiry by the state regarding a claim for payment for any health care item or service that is submitted no later than three years after the date of the provision of the item or service, respond to such inquiry, pursuant to 42 U.S.C. Section 1396a(25)(I)(iii) as amended to July 1, 2026.

b. Agree not to deny any claim submitted by the state solely because of the date of submission of the claim, the type or format of the claim form, a failure to present proper documentation at the point of sale that is the basis of the claim, or, in the case of a responsible third party (other than the original Medicare fee-for-service program under Parts A and B of 42 U.S.C. Chapter 7, Subchapter

XVIII as amended to July 1, 2026, a Medicare Advantage plan offered by a Medicare Advantage organization under Part C of 42 U.S.C. Chapter 7, Subchapter XVIII as amended to July 1, 2026, a reasonable cost of reimbursement plan under 42 U.S.C. Section 1395mm as amended to July 1, 2026, a health care prepayment plan under 42 U.S.C. Section 1395l as amended to July 1, 2026, or a prescription drug plan (PDP) offered by a PDP sponsor under Part D of 42 U.S.C. Chapter 7, Subchapter XVIII as amended to July 1, 2026), a failure to obtain a prior authorization for the item or service for which the claim is being submitted, if both of the following conditions are met:

(1) The claim is submitted to the entity by the state within the three-year period beginning on the date on which the item or service was furnished.

(2) Any action by the state to enforce its rights with respect to the claim is commenced within six years of the date that the claim was submitted by the state.

c. Reimburse the Medicaid program within 90 days of the request for repayment.

d. Agree not to deny any claim submitted by the state solely because of lack of prior authorization.

[ARC 0317D, IAB 5/27/26, effective 7/1/26]

441—80.3(249A) Time limit for submission of claims and claim adjustments.

80.3(1) *Submission of claims.* Payment will not be made on any claim when the amount of time that has elapsed between the date the service was rendered and the date the initial claim is received by Iowa Medicaid exceeds 365 days. The department will consider claims submitted beyond the 365-day limit for payment only if retroactive eligibility on newly approved cases is made that exceeds 365 days or if attempts to collect from a third-party payer delay the submission of a claim. In the case of retroactive eligibility, the claim must be received within 365 days of the first notice of eligibility by the department.

80.3(2) *Claim adjustments and resubmissions.* A provider's request for an adjustment to a paid claim or resubmission of a denied claim must be received by Iowa Medicaid within 365 days from the date the claim was last adjudicated in order to have the adjustment or resubmission considered. In no case will a claim be paid if the claim is received beyond two years from the date of service.

80.3(3) *Definition.* For purposes of this rule, a claim is "received" when entered into the department's payment system with an action of pay, deny, or suspend. Any claim returned to the provider without such action is not "received."

[ARC 0317D, IAB 5/27/26, effective 7/1/26]

441—80.4(249A) Authorization process.

80.4(1) *Identification cards.* The department will issue a medical assistance eligibility card to members for use in securing medical and health services available under the program except as provided in 441—Chapter 76.

a. The department will issue the medical assistance eligibility card:

(1) When the member's eligibility is initially determined.

(2) Upon the member's request for replacement of a lost, stolen, or damaged card.

b. The medical assistance eligibility card is valid only for months in which the member has established eligibility as indicated on the department's eligibility verification system (ELVS). Payment will be made for services provided to an ineligible person when ELVS indicates that the person was eligible for the period in which the service was provided.

80.4(2) Reserved.

[ARC 0317D, IAB 5/27/26, effective 7/1/26]

441—80.5(249A) Payment to provider—exception. Payments for medical services may be made only to the provider of the services except as provided below.

80.5(1) *Medical assistance corrective payments.* Payment may be made to the client or county relief agency in accordance with 441—Chapter 75.

80.5(2) *Assignment.* Payment may be made in accordance with an assignment to a county for medical services received while the recipient was receiving interim assistance or while an appeal of a denial of medical assistance was pending.

80.5(3) *Business agent of provider.* Payment may be made to a business agent that furnishes statements and receives payments in the name of the provider if the agent's compensation is:

- a. Related to the cost of processing the billing.
- b. Not related on a percentage or other basis to the amount that is billed or collected.
- c. Not dependent upon the collection of the payment.

[ARC 0317D, IAB 5/27/26, effective 7/1/26]

441—80.6(249A) Health care data match program. As a condition of doing business in Iowa, health insurers shall provide, upon the request of the state, information with respect to individuals who are eligible for or are provided medical assistance under the state's medical assistance plan to determine (1) during what period the member or the member's spouse or dependents may be or may have been covered by a health insurer and (2) the nature of the coverage that is or was provided by the health insurer. This requirement applies to self-insured plans, group health plans as defined in the federal Employee Retirement Income Security Act of 1974 (Public Law 93-406 as amended to July 1, 2026), service benefit plans, managed care organizations, pharmacy benefits managers, and other parties that are, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service.

80.6(1) *Agreement required.* The parties shall sign a data use agreement for the purposes of this rule. A data use agreement shall prescribe the specific detail elements required, any privacy protections, the manner in which information shall be provided to the department or its designee, and the acceptable uses of the information provided.

a. The initial provision of data shall include the data necessary to enable the department or its designee to match covered persons and identify third-party payors for the two-year period before the initial provision of the data. The data shall include the name, address, and identifying number of the plan.

b. Ongoing monthly matches may be limited to changes in the data previously provided, including additional covered persons, with the effective dates of the changes.

80.6(2) *Confidentiality of data.* The exchange of information carried out under this rule shall be consistent with all laws, regulations, and rules relating to the confidentiality or privacy of personal information or medical records, including but not limited to:

a. The federal Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, as amended to July 1, 2026; and

b. Regulations promulgated in accordance with that Act and published in 45 CFR Parts 160 through 164 as amended to July 1, 2026.

[ARC 0317D, IAB 5/27/26, effective 7/1/26]

These rules are intended to implement Iowa Code chapter 249A.

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◇ Two or more ARCs

CHAPTER 83
MEDICAID WAIVER SERVICES

Chapter rescission date pursuant to Iowa Code section 17A.7: 7/1/31

DIVISION I—HCBS HEALTH AND DISABILITY WAIVER SERVICES

441—83.1(249A) Definitions.

“Blind” means an individual has a central visual acuity of 20/200 or less in the better eye with the use of a corrective lens or visual field restriction to 20 degrees or less.

“Client participation” means the amount of the recipient income that the person must contribute to the cost of health and disability waiver services exclusive of medical vendor payments before Medicaid will participate.

“Deeming” means the specified amount of parental or spousal income and resources considered in determining eligibility for a child or spouse according to current supplemental security income guidelines.

“Disabled” means an individual is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment that has lasted or is expected to last for a continuous period of not less than 12 months. A child under the age of 18 is considered disabled if the child suffers a medically determinable physical or mental impairment of comparable severity.

“DSM-5” means the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, published by the American Psychiatric Association as amended to July 1, 2026.

“Financial participation” means client participation and medical payments from a third party including veterans’ aid and attendance.

“Guardian” means a guardian appointed in probate court.

“Intermediate care facility for persons with an intellectual disability level of care” means that the individual has a diagnosis of intellectual disability made in accordance with the criteria provided in DSM-5 or has a related condition as defined in 42 CFR 435.1009 as amended to July 1, 2026, and needs assistance in at least three of the following major life areas: mobility, musculoskeletal skills, activities of daily living, domestic skills, toileting, eating skills, vision, hearing or speech or both, gross/fine motor skills, sensory-taste, smell, tactile, academic skills, vocational skills, social/community skills, behavior, and health care.

“Managed care” means a system that provides the coordinated delivery of services and supports that are necessary and appropriate, delivered in the least restrictive settings and in the least intrusive manner. Managed care seeks to balance three factors:

1. Achieving high-quality outcomes for participants.
2. Coordinating access.
3. Containing costs.

“Managed care organization” or *“MCO”* means an entity that (1) is under contract with the department to provide services to Medicaid recipients and (2) meets the definition of “health maintenance organization” as defined in Iowa Code section 514B.1.

“Medical assessment” means a visual and physical inspection of the member, noting deviations from the norm, and a statement of the member’s mental and physical condition that can be amendable to or resolved by appropriate actions of the provider.

“Medical institution” means a nursing facility or an intermediate care facility for persons with an intellectual disability that has been approved as a Medicaid vendor.

“Medical intervention” means member care in the areas of hygiene, mental and physical comfort, assistance in feeding and elimination, and control of the member’s care and treatment to meet the physical and mental needs of the member in compliance with the plan of care in areas of health, prevention, restoration, and maintenance.

“Medical monitoring” means observation for the purpose of assessing, preventing, maintaining, and treating disease or illness based on the member’s plan of care.

“Member” means an individual who has been determined to be eligible and has been enrolled to receive Medicaid pursuant to rule 441—75.3(249A) or 441—75.6(249A), excluding medically needy, and is a recipient of waiver services.

“Nursing facility level of care” means that the following conditions are met:

1. The presence of a physical or mental impairment that restricts the member’s daily ability to perform the essential activities of daily living, bathing, dressing, and personal hygiene and impedes the member’s capacity to live independently.
2. The member’s physical or mental impairment is such that self-execution of required nursing care is improbable or impossible.

“Service plan” means a person-centered, outcome-based plan of services that is written by the member’s case manager with input and direction from the member and that addresses all relevant services and supports being provided. The service plan is developed by the interdisciplinary team, which includes the member and, if appropriate, the member’s legal representative, the member’s family, service providers, and others directly involved with the member.

“Skilled nursing facility level of care” means that the following conditions are met:

1. The member’s medical condition requires skilled nursing services or skilled rehabilitation services as defined in 42 CFR 409.31(a), 409.32, and 409.34 as amended to July 1, 2026.
2. Services are provided in accordance with the general provisions for all Medicaid providers and services as described in rule 441—79.10(249A).
3. Documentation submitted for review indicates that the member has:
 - A physician order for all skilled services.
 - Services that require the skills of medical personnel, including registered nurses, licensed practical nurses, physical therapists, occupational therapists, speech pathologists, or audiologists.
 - An individualized care plan that identifies support needs.
 - Confirmation that skilled services are provided to the member.
 - Skilled services that are provided by, or under the supervision of, medical personnel as described above.
 - Skilled nursing services that are needed and provided seven days a week or skilled rehabilitation services that are needed and provided at least five days a week.

“Substantial gainful activity” means productive activities that add to the economic wealth, or produce goods or services to which the public attaches a monetary value.

“Third-party payment” means payment from an attorney, individual, institution, corporation, or public or private agency that is liable to pay part or all of the medical costs incurred as a result of injury, disease or disability by or on behalf of an applicant or a past or present recipient of medical assistance.

“Usual caregiver” means a person or persons who reside with the member and are available on a 24-hour-per-day basis to assume responsibility for the care of the member.

[ARC 0318D, IAB 5/27/26, effective 7/1/26]

441—83.2(249A) Eligibility. To be eligible for health and disability waiver services, a person must meet certain eligibility criteria and be determined to need a service(s) allowable under the program.

83.2(1) Eligibility criteria.

a. The person must be under the age of 65 and blind or disabled as determined by the receipt of social security disability benefits or by a disability determination made through the department. Disability determinations are made according to supplemental security income guidelines under Title XVI of the Social Security Act as amended to July 1, 2026.

b. Reserved.

c. Persons shall meet the eligibility requirements of the supplemental security income program except for the following:

(1) The person is under 18 years of age, unmarried and not the head of a household and is ineligible for supplemental security income because of the deeming of the parent's(s') income.

(2) The person is married and is ineligible for supplemental security income because of the deeming of the spouse's income or resources.

(3) The person is ineligible for supplemental security income due to excess income and the person's income does not exceed 300 percent of the maximum monthly payment for one person under supplemental security income.

(4) The person is under 18 years of age and is ineligible for supplemental security income because of excess resources.

d. The person must be certified as being in need of nursing facility or skilled nursing facility level of care or as being in need of care in an intermediate care facility for persons with an intellectual disability, based on information submitted on a completed information submission tool for children aged 3 and under, the interRAI - Pediatric Home Care (PEDS-HC) for those aged 4 to 20, or the interRAI - Home Care (HC) for those aged 21 to 64 and other supporting documentation as relevant. The information submission tool, the interRAI - PEDS-HC and the interRAI - HC are available upon request from Iowa Medicaid. Copies of the completed information submission tool for an individual are available to that individual from the individual's case manager or MCO.

(1) The member's designated case manager shall use the completed assessment to develop the comprehensive service plan as specified in 441—paragraph 90.4(1) "b."

(2) Iowa Medicaid will be responsible for the initial determination of the member's level of care certification. Iowa Medicaid or the member's MCO will be responsible for annual redetermination of the level of care.

(3) Health and disability waiver services will not be provided when the person is an inpatient in a medical institution.

(4) The MCO must submit documentation to Iowa Medicaid for all reassessments, performed at least annually, that indicate a change in the member's level of care. Iowa Medicaid will make a final determination for any reassessments that indicate a change in the level of care. If the level of care reassessment indicates no change in level of care, the member is approved to continue at the already established level of care.

e. To be eligible for interim medical monitoring and treatment services the member must be:

(1) Under the age of 21;

(2) Currently receiving home health agency services under rule 441—78.9(249A) and require medical assessment, medical monitoring, and regular medical intervention or intervention in a medical emergency during those services. (The home health aide services for which the member is eligible must be maximized before the member accesses interim medical monitoring and treatment.);

(3) Residing in the member's family home or foster family home; and

(4) In need of interim medical monitoring and treatment as ordered by a physician, nurse practitioner, clinical nurse specialist, or physician associate.

f. The person must meet income and resource guidelines for Medicaid as if in a medical institution pursuant to 441—Chapter 75. When a husband and wife who are living together both apply for the waiver, income and resource guidelines as specified in 441—paragraphs 75.82(2) "b" and 75.82(4) "c" will be applied.

g. The person must have service needs that can be met by this waiver program. At a minimum a person must receive one billable unit of service under the waiver per calendar quarter.

h. To be eligible for the consumer choices option as set forth in 441—subrule 78.34(13), a person cannot be living in a residential care facility.

83.2(2) *Need for services.*

a. The member shall have a service plan approved by the department that is developed by the designated case manager. This service plan must be completed prior to services provision and annually thereafter.

The designated case manager will establish the interdisciplinary team for the member and, with the team, identify the member's need for service based on the member's needs and desires as well as the availability and appropriateness of services, using the following criteria:

(1) This service plan will be based, in part, on information in the completed information submission tool listed in paragraph 83.2(1) "d" and other supporting documentation as relevant. The designated case manager will have a face-to-face visit with the member at least quarterly.

(2) Service plans for persons aged 20 or under shall be developed to reflect use of all appropriate nonwaiver Medicaid services and so as not to replace or duplicate those services. The designated case manager shall list all nonwaiver Medicaid services in the service plan.

(3) Service plans for persons aged 20 or under that include home health or nursing services will not be approved until a home health agency has made a request to cover the member's service needs through nonwaiver Medicaid services.

b. Except as provided below, the total monthly cost of the health and disability waiver services, excluding the cost of home and vehicle modification services, shall not exceed the established aggregate monthly cost for level of care as follows:

<u>Skilled level of care</u>	<u>Nursing level of care</u>	<u>ICF/ID</u>
\$3,166.53	\$1,087.96	\$4,244.04

For members enrolled in the health and disability waiver in accordance with subrule 83.2(1), when a member turns 21 years of age, the average monthly cost of services received through 441—subrule 78.9(10) will be used to increase the monthly waiver budget in accordance with the following:

(1) The member must request the revised waiver budget through the member's case manager no earlier than two months before, and no later than six months after, the member's twenty-first birthday. A renewal request must be received annually no earlier than two months before, and no later than six months after, each subsequent birthday.

(2) The member's waiver budget will be increased by the average monthly cost of state plan private duty nursing or personal care services for the member that was billed to and paid by Iowa Medicaid or an Iowa Medicaid-contracted MCO during the year in which the member is 20 years of age.

(3) Once the request is received by the department, the department will determine the average monthly cost pursuant to the claims data available at the time of the request. No subsequent claims data shall be considered.

(4) The revised waiver budget reflecting the average cost of state plan private duty nursing or personal care services will become effective on the later of the first day of the month of the member's twenty-first birthday or the first day of the month of the completed review.

(5) The revised waiver budget will extend up to the first of the month following the member's twenty-fifth birthday and will remain at the initially authorized amount for the member while aged 21 through 24.

c. Interim medical monitoring and treatment services must be needed because all usual caregivers are unavailable to provide care due to one of the following circumstances:

(1) Employment. Interim medical monitoring and treatment services are to be received only during hours of employment.

(2) Academic or vocational training. Interim medical monitoring and treatment services provided while a usual caregiver participates in postsecondary education or vocational training will be limited to 24 periods of no more than 30 days each per caregiver as documented by the service worker or targeted case manager. Time spent in high school completion, adult basic education, GED, or English as a second language does not count toward the limit.

(3) Absence from the home due to hospitalization, treatment for physical or mental illness, or death of the usual caregiver. Interim medical monitoring and treatment services under this subparagraph are limited to a maximum of 30 days.

(4) Search for employment.

1. Care during job search will be limited to only those hours the usual caregiver is actually looking for employment, including travel time.

2. Interim medical monitoring and treatment services may be provided under this paragraph only during the execution of one job search plan of up to 30 working days in a 12-month period, approved by the department service worker or targeted case manager pursuant to 441—subparagraph 170.2(2) “b”(5).

3. Documentation of job search contacts shall be furnished to the department service worker or targeted case manager.

[ARC 0318D, IAB 5/27/26, effective 7/1/26]

441—83.3(249A) Application.

83.3(1) *Application for HCBS health and disability waiver services.* The application process as specified in rules 441—76.1(249A) through 441—76.6(249A) shall be followed.

83.3(2) *Application and services program limit.* The number of persons who may be approved for the HCBS health and disability waiver will be subject to the number of members to be served as set forth in the federally approved HCBS health and disability waiver. The number of members to be served is set forth at the time of each five-year renewal of the waiver or in amendments to the waiver approved by the Centers for Medicare and Medicaid Services (CMS). When the number of applicants exceeds the number of members specified in the approved waiver, the applicant’s name will be placed on a waiting list maintained by Iowa Medicaid.

a. The department field office will enter all waiver applications into the institutional and waiver service and narrative system (IoWANS) to determine whether a payment slot is available.

(1) For applicants not currently receiving Medicaid, the department field office will make the entry by the end of the fifth working day after receipt of a completed application for health coverage and help paying costs or within five working days after receipt of disability determination, whichever is later.

(2) For current Medicaid members, the department field office will make the entry by the end of the fifth working day after receipt of a written request signed and dated by the applicant.

(3) A payment slot will be assigned to the applicant upon confirmation of an available slot.

(4) Once a payment slot is assigned, the department field office will give written notice to the applicant. The department will hold the payment slot for the applicant as long as reasonable efforts are being made to arrange services and the applicant has not been determined to be ineligible for the program. If services have not been initiated and reasonable efforts are no longer being made to arrange services, the slot will revert for use by the next person on the waiting list, if applicable. The applicant originally assigned the slot must reapply for a new slot.

b. If no payment slot is available, the department will enter persons on a waiting list according to the following:

(1) Applicants not currently eligible for Medicaid will be entered on the waiting list on the basis of the date a completed application for health coverage and help paying costs is received by the department or upon receipt of disability determination, whichever is later.

(2) Applicants currently eligible for Medicaid will be added to the waiting list on the basis of the date a request as specified in subparagraph 83.3(2) “a”(2) is received by the department.

(3) In the event that more than one application is received at one time, persons shall be entered on the waiting list on the basis of the month of birth, January being month one and the lowest number.

(4) Applicants who do not fall within the available slots will have their application rejected, and their names will be maintained on the waiting list. They will be contacted to reapply as slots become available based on their order on the waiting list so that the number of approved persons on the program is maintained. Iowa Medicaid will contact the department field office when a slot becomes available.

(5) Once a payment slot is assigned, the department field office will give written notice to the person within five working days. The department will hold the payment slot for 30 days for the person to file a new application. If an application has not been filed within 30 days, the slot will revert for use by the next person on the waiting list, if applicable. The person originally assigned the slot must reapply for a new slot.

c. The department field office will notify Iowa Medicaid within five working days of the receipt of an application and of any action on or withdrawal of an application.

83.3(3) *Approval of application.*

a. Applications for the HCBS health and disability waiver program will be processed in 30 days unless one or more of the following conditions exist:

(1) An application has been filed and is pending for federal supplemental security income benefits.

(2) The application is pending because the department has not received information that is beyond the control of the client or the department.

(3) The application is pending due to the disability determination process performed through the department.

(4) The application is pending because a level of care determination has not been made although the required assessment has been submitted to Iowa Medicaid.

(5) The application is pending because the required assessment has not been completed. When a determination is not completed 90 days from the date of application due to the lack of a completed assessment, the application will be denied.

b. Decisions will be mailed or given to the applicant on the date when income maintenance eligibility and level of care determinations are completed.

c. An applicant must be given the choice between HCBS health and disability waiver services and institutional care. The applicant, parent, guardian, or attorney in fact under a durable power of attorney for health care shall sign the assessment and indicate that the applicant has elected home- and community-based services.

d. Waiver services provided prior to approval of eligibility for the waiver cannot be paid.

e. A member may be enrolled in only one waiver program at a time. Costs for waiver services are not reimbursable while the member is in a medical institution (hospital or nursing facility) or residential facility. Services will not be simultaneously reimbursed for the same time period as Medicaid or other Medicaid waiver services.

83.3(4) *Effective date of eligibility.*

a. Deeming of parental or spousal income and resources ceases and eligibility will be effective on the date the income and resource eligibility and level of care determinations are completed but will not be earlier than the first of the month following the date of application.

b. The effective date of eligibility for the health and disability waiver for persons who qualify for Medicaid due to eligibility for the waiver services and to whom paragraphs 83.3(4)“a” and “c” do not apply is the date on which the income eligibility and level of care determinations are completed.

c. Eligibility for persons covered under subparagraph 83.2(1)“c”(3) will exist on the date the income and resource eligibility and level of care determinations are completed but will not be earlier than the first of the month following the date of application.

d. Eligibility continues until the member has been in a medical institution for 120 consecutive days for other than respite care. Members who are inpatients in a medical institution for 120 or more consecutive days for other than respite care will be terminated from health and disability waiver services and reviewed for eligibility for other Medicaid coverage groups. The member will be notified of that decision through a notice of decision. If the member returns home before the effective date of the notice of decision and the member’s condition has not substantially changed, the denial may be rescinded and eligibility may continue.

83.3(5) *Attribution of resources.* For the purposes of attributing resources as provided in rule 441—75.82(249A), the date on which the waiver applicant met the level of care criteria in a medical

institution as established by the peer review organization will be used as the date of entry to the medical institution. Only one attribution of resources shall be completed per person. Attributions completed for prior institutionalizations will be applied to the waiver application.

[ARC 0318D, IAB 5/27/26, effective 7/1/26]

441—83.4(249A) Financial participation. Persons must contribute their predetermined financial participation to the cost of health and disability waiver services or other Medicaid services, as applicable.

83.4(1) *Maintenance needs of the individual.* The maintenance needs of the individual will be computed by deducting an amount that is 300 percent of the maximum monthly payment for one person under supplemental security income (SSI) from the client's total income.

83.4(2) *Limitation on payment.* If the sum of the third-party payment and client participation equals or exceeds the reimbursement established by the service worker or targeted case manager for health and disability waiver services, Medicaid will make no payments to health and disability waiver service providers. However, Medicaid will make payments to other medical vendors, as applicable.

[ARC 0318D, IAB 5/27/26, effective 7/1/26]

441—83.5(249A) Redetermination. A complete redetermination of eligibility for the health and disability waiver shall be completed at least once every 12 months or when there is significant change in the person's situation or condition. A redetermination of continuing eligibility factors shall be made in accordance with rules 441—76.17(249A) and 441—83.2(249A). A redetermination shall include verification of the existence of a current service plan meeting the requirements listed in rule 441—83.7(249A).

83.5(1) The department or the member's MCO will be responsible for annual redetermination of the level of care.

83.5(2) The MCO must submit documentation to the department for all reassessments, performed at least annually, that indicate a change in the member's level of care. The department will make a final determination for any reassessments that indicate a change in the level of care. If the level of care reassessment indicates no change in level of care, the member is approved to continue at the already established level of care.

[ARC 0318D, IAB 5/27/26, effective 7/1/26]

441—83.6(249A) Allowable services. Services allowable under the health and disability waiver are homemaker, home health, adult day care, respite care, nursing, counseling, consumer-directed attendant care, interim medical monitoring and treatment, home and vehicle modification, personal emergency response system, home-delivered meals, nutritional counseling, financial management, independent support brokerage, self-directed personal care, self-directed community supports and employment, and individual-directed goods and services as set forth in rule 441—78.34(249A).

[ARC 0318D, IAB 5/27/26, effective 7/1/26]

441—83.7(249A) Service plan. A service plan shall be prepared for health and disability waiver members in accordance with 441—paragraph 90.4(1) "b." Service plans for both children and adults shall be completed every 12 months or when there is significant change in the person's situation or condition.

83.7(1) The service plan shall include the frequency of the health and disability waiver services and the types of providers that will deliver the services.

83.7(2) The service plan shall indicate whether the member has elected the consumer choices option. If the member has elected the consumer choices option, the service plan shall identify:

- a. The independent support broker selected by the member; and
- b. The financial management service selected by the member.

83.7(3) The service plan shall also list all nonwaiver Medicaid services.

83.7(4) The service plan shall identify a plan for emergencies and the supports available to the member in an emergency.

[ARC 0318D, IAB 5/27/26, effective 7/1/26]

441—83.8(249A) Adverse service actions.

83.8(1) Denial. An application for services will be denied when it is determined by the department that:

- a. The client is not eligible for or in need of services.
- b. Needed services are not available or received from qualified providers.
- c. Service needs exceed the aggregate monthly costs established in paragraph 83.2(2) “b,” or are not met by the services provided.
- d. Needed services are not available or received from qualifying providers.

83.8(2) Termination. A particular service may be terminated when the department determines that:

- a. The provisions of 441—paragraph 130.5(2) “a,” “b,” “c,” “g,” or “h” apply.
- b. The costs of the health and disability waiver service for the person exceed the aggregate monthly costs established in paragraph 83.2(2) “b.”
- c. The member receives care in a hospital, nursing facility, or intermediate care facility for persons with an intellectual disability for 120 days in any one stay for purposes other than respite care.
- d. The member receives health and disability waiver services and the physical or mental condition of the member requires more care than can be provided in the member’s own home as determined by the designated case manager.
- e. Service providers are not available.

83.8(3) Reduction. Reduction of services will apply as specified in 441—paragraphs 130.5(3) “a” and “b.”

[ARC 0318D, IAB 5/27/26, effective 7/1/26]

441—83.9(249A) Appeal rights. Notice of adverse action will be given in accordance with rule 441—16.2(17A). The right to appeal will be given in accordance with 441—Chapter 2506.

[ARC 0318D, IAB 5/27/26, effective 7/1/26]

441—83.10 to 83.20 Reserved.

These rules are intended to implement Iowa Code sections 249A.3 and 249A.4.

DIVISION II—HCBS ELDERLY WAIVER SERVICES

441—83.21(249A) Definitions.

“*Basic individual respite*” means respite provided on a staff-to-member ratio of one to one or higher to individuals without specialized needs requiring the care of a licensed registered nurse or licensed practical nurse.

“*Case management*” means the categories of case management: targeted case management, case management provided to members enrolled in a 1915(c) waiver, and community-based case management provided through managed care.

“*Case manager*” means the staff person providing all categories of case management services regardless of the entity providing the service or the program in which the member is enrolled.

“*Client participation*” means the amount of the recipient income that the person must contribute to the cost of elderly waiver services exclusive of medical vendor payments before Medicaid will participate.

“*Guardian*” means a guardian appointed in probate court.

“*Interdisciplinary team*” means a collection of persons with varied professional backgrounds who develop one plan of care to meet a client’s need for services.

“Managed care” means a system that provides the coordinated delivery of services and supports that are necessary and appropriate, delivered in the least restrictive settings and in the least intrusive manner. Managed care seeks to balance three factors:

1. Achieving high-quality outcomes for participants.
2. Coordinating access.
3. Containing costs.

“Managed care organization” or *“MCO”* means an entity that (1) is under contract with the department to provide services to Medicaid recipients and (2) meets the definition of “health maintenance organization” as defined in Iowa Code section 514B.1.

“Medical institution” means a nursing facility that has been approved as a Medicaid vendor.

“Member” means an individual who has been determined eligible and has been enrolled to receive Medicaid pursuant to rule 441—75.3(249A) or 441—75.6(249A), excluding medically needy, and is a recipient of waiver services.

“Nursing facility level of care” means that the following conditions are met:

1. The presence of a physical or mental impairment that restricts the member’s daily ability to perform the essential activities of daily living, bathing, dressing, and personal hygiene, and impedes the member’s capacity to live independently.
2. The member’s physical or mental impairment is such that self-execution of required nursing care is improbable or impossible.

“Service plan” means a person-centered, outcome-based plan of services that is written by the member’s case manager with input and direction from the member and that addresses all relevant services and supports being provided. The service plan is developed by the interdisciplinary team, which includes the member and, if appropriate, the member’s legal representative, member’s family, service providers, and others directly involved with the member.

“Skilled nursing facility level of care” means that the following conditions are met:

1. The member’s medical condition requires skilled nursing services or skilled rehabilitation services as defined in 42 CFR 409.31(a), 409.32, and 409.34 as amended to July 1, 2026.
2. Services are provided in accordance with the general provisions for all Medicaid providers and services as described in rule 441—79.10(249A).
3. Documentation submitted for review indicates that the member has:
 - A physician order for all skilled services.
 - Services that require the skills of medical personnel, including registered nurses, licensed practical nurses, physical therapists, occupational therapists, speech pathologists, or audiologists.
 - An individualized care plan that identifies support needs.
 - Confirmation that skilled services are provided to the member.
 - Skilled services that are provided by, or under the supervision of, medical personnel as described above.
 - Skilled nursing services that are needed and provided seven days a week or skilled rehabilitation services that are needed and provided at least five days a week.

“Third-party payment” means payment from an individual, institution, corporation, or public or private agency that is liable to pay part or all of the medical costs incurred as a result of injury, disease or disability by or on behalf of an applicant or a past or present recipient of medical assistance.

“Usual caregiver” means a person or persons who reside with the member and are available on a 24-hour-per-day basis to assume responsibility for the care of the member.

[ARC 0318D, IAB 5/27/26, effective 7/1/26]

441—83.22(249A) Eligibility. To be eligible for elderly waiver services a person must meet certain eligibility criteria and be determined to need a service(s) allowable under the program.

83.22(1) Eligibility criteria. All of the following criteria must be met. The person must be:

- a. Sixty-five years of age or older.
- b. A resident of the state of Iowa.

c. Eligible for Medicaid as if in a medical institution pursuant to 441—Chapter 75. When a husband and wife who are living together both apply for the waiver, income and resource guidelines as specified in 441—paragraphs 75.82(2) “b” and 75.82(4) “c” will be applied.

d. Certified as being in need of the intermediate or skilled level of care based, in part, on information submitted on the interRAI - Home Care (HC). The interRAI - HC is available on request from the department and other supporting documentation as relevant. Copies of the completed interRAI - HC for an individual are available to that individual from the individual’s case manager or MCO.

(1) The assessment will be completed when the person applies for waiver services, upon request to report a significant change in the person’s condition, and annually for reassessment of the person’s level of care. The department will be responsible for determination of the initial level of care.

(2) The department or the member’s MCO will be responsible for annual redetermination of the level of care.

(3) Elderly waiver services will not be provided when the person is an inpatient in a medical institution.

(4) The MCO must submit documentation to the department for all reassessments, performed at least annually, that indicate a change in the member’s level of care. The department will make a final determination for any reassessments that indicate a change in the level of care. If the level of care reassessment indicates no change in level of care, the member is approved to continue at the already established level of care.

e. Determined to need services as described in subrule 83.22(2).

f. For the consumer choices option as set forth in 441—subrule 78.34(13), residing in a living arrangement other than a residential care facility.

83.22(2) *Need for services, service plan, and cost.*

a. *Case management.* Members under the elderly waiver will receive case management services from a provider qualified pursuant to rule 441—77.38(249A). Case management services will be provided as set forth in rules 441—90.4(249A) through 441—90.7(249A).

b. *Interdisciplinary team.* The case manager will establish an interdisciplinary team for the member.

(1) *Composition.* The interdisciplinary team will include the case manager and the member and, if appropriate, the member’s legal representative, family, service providers, and others directly involved in the member’s care.

(2) *Role.* The team will identify:

1. The member’s need for services based on the member’s needs and desires.
2. Available and appropriate services to meet the member’s needs.
3. Health and safety issues for the member that indicate the need for an emergency plan, based on a risk assessment conducted before the team meeting.

4. Emergency backup support and a crisis response system to address problems or issues arising when support services are interrupted or delayed or when the member’s needs change.

c. *Service plan.* An applicant for elderly waiver services will have a service plan developed by a qualified provider of case management services under the elderly waiver.

(1) Services included in the service plan will be appropriate to the problems and specific needs or disabilities of the member.

(2) Services must be the least costly available to meet the service needs of the member.

(3) The service plan must be completed before services are provided.

(4) The service plan must be reviewed at least annually and when there is any significant change in the member’s needs.

d. *Content of service plan.* The service plan will include the following information based on the member’s current assessment and service needs:

(1) Observable or measurable individual goals.

(2) Interventions and supports needed to meet those goals.

- (3) Incremental action steps, as appropriate.
- (4) The names of staff, people, businesses, or organizations responsible for carrying out the interventions or supports.
- (5) The desired individual outcomes.
- (6) The identified activities to encourage the member to make choices, to experience a sense of achievement, and to modify or continue participation in the service plan.
- (7) Description of any restrictions on the member's rights, including the need for the restriction and a plan to restore the rights. For this purpose, rights include maintenance of personal funds and self-administration of medications.
- (8) A list of all Medicaid and non-Medicaid services that the member received at the time of waiver program enrollment that includes:
 1. The name of the service provider responsible for providing the service.
 2. The funding source for the service.
 3. The amount of service that the member is to receive.
- (9) Indication of whether the member has elected the consumer choice option and, if so, the independent support broker and the financial management service that the member has selected.
- (10) The determination that the services authorized in the service plan are the least costly.
- (11) A plan for emergencies that identifies the supports available to the member in situations for which no approved service plan exists and that, if not addressed, may result in injury or harm to the member or other persons or in significant amounts of property damage. Emergency plans will include:
 1. The member's risk assessment and the health and safety issues identified by the member's interdisciplinary team.
 2. The emergency backup support and crisis response system identified by the interdisciplinary team.
 3. Emergency, backup staff designated by providers for applicable services.

[ARC 0318D, IAB 5/27/26, effective 7/1/26]

441—83.23(249A) Application.

83.23(1) *Application for HCBS elderly waiver.* The application process as specified in rules 441—76.1(249A) through 441—76.6(249A) shall be followed.

83.23(2) *Approval of application.*

- a.* Applications for the elderly waiver program will be processed in 30 days unless the worker can document difficulty in locating and arranging services or circumstances beyond the worker's control. In these cases a decision will be made as soon as possible.
- b.* Decisions will be mailed or given to the applicant on the date when both service and income maintenance eligibility determinations are completed.
- c.* An applicant must be given the choice between elderly waiver services and institutional care. The applicant, guardian, or attorney in fact under a durable power of attorney for health care shall sign the information submission tool specified in paragraph 83.22(1) "d," indicating that the applicant has elected waiver services.
- d.* Waiver services provided prior to approval of eligibility for the waiver cannot be paid.

83.23(3) *Effective date of eligibility.*

- a.* The effective date of eligibility is the date on which the income eligibility and level of care determinations are completed.
- b.* Eligibility for persons whose income exceeds supplemental security income guidelines will not exist until the persons require care in a medical institution for a period of 30 consecutive days and will be effective no earlier than the first day of the month in which the 30-day period begins.
- c.* Eligibility continues until the member has been in a medical institution for 120 consecutive days for other than respite care or fails to meet eligibility criteria listed in rule 441—83.22(249A). Members who are inpatients in a medical institution for 120 or more consecutive days for other than respite care will be terminated from elderly waiver services and reviewed for eligibility for other

Medicaid coverage groups. The member will be notified of that decision through a notice of decision. If the member returns home before the effective date of the notice of decision and the member's condition has not substantially changed, the denial may be rescinded and eligibility may continue.

83.23(4) *Attribution of resources.* For the purposes of attributing resources as provided in rule 441—75.82(249A), the date on which the waiver applicant met the level of care criteria in a medical institution as established by the peer review organization will be used as the date of entry to the medical institution. Only one attribution of resources will be completed per person. Attributions completed for prior institutionalizations will be applied to the waiver application.

[ARC 0318D, IAB 5/27/26, effective 7/1/26]

441—83.24(249A) Client participation. Persons must contribute their predetermined client participation to the cost of elderly waiver services.

83.24(1) *Computation of client participation.* Client participation will be computed by deducting an amount for the maintenance needs of the individual that is 300 percent of the maximum supplemental security income (SSI) grant for an individual from the client's total income.

83.24(2) *Limitation on payment.* If the sum of the third-party payment and client participation equals or exceeds the reimbursement established by the service worker, Medicaid will make no payments for elderly waiver service providers. However, Medicaid will make payments to other medical vendors.

[ARC 0318D, IAB 5/27/26, effective 7/1/26]

441—83.25(249A) Redetermination. A complete redetermination of eligibility for elderly waiver services will be done at least once every 12 months. A redetermination of continuing eligibility factors will be made when a change in circumstances occurs that affects eligibility in accordance with rule 441—83.22(249A). A redetermination will contain the components listed in rule 441—83.27(249A).

83.25(1) The department or the member's MCO will be responsible for annual redetermination of the level of care.

83.25(2) The MCO must submit documentation to the department for all reassessments, performed at least annually, that indicate a change in the member's level of care. The department will make a final determination for any reassessments that indicate a change in the level of care. If the level of care reassessment indicates no change in level of care, the member is approved to continue at the already established level of care.

[ARC 0318D, IAB 5/27/26, effective 7/1/26]

441—83.26(249A) Allowable services. Services allowable under the elderly waiver are case management, adult day care, emergency response system, homemaker, home health aide, nursing, respite care, chore, home-delivered meals, home and vehicle modification, mental health outreach, transportation, nutritional counseling, assistive devices, senior companions, consumer-directed attendant care, financial management, independent support brokerage, self-directed personal care, self-directed community supports and employment, and individual-directed goods and services as set forth in rule 441—78.37(249A).

[ARC 0318D, IAB 5/27/26, effective 7/1/26]

441—83.27(249A) Service plan. The service plan will be completed jointly by the member, the elderly waiver case manager, and any other person identified by the member.

83.27(1) The service plan will indicate whether the member has elected the consumer choices option. If the member has elected the consumer choices option, the service plan will identify:

- a. The independent support broker selected by the member; and
- b. The financial management service selected by the member.

83.27(2) The service plan will identify a plan for emergencies and the supports available to the member in an emergency.

[ARC 0318D, IAB 5/27/26, effective 7/1/26]

441—83.28(249A) Adverse service actions.

83.28(1) Denial. An application for services will be denied when it is determined by the department that:

- a. The client is not eligible for or in need of services.
- b. Except for respite care, the elderly waiver services are not needed on a regular basis.
- c. Service needs are not met by services provided.
- d. Needed services are not available or received from qualifying providers.

83.28(2) Termination. A particular service may be terminated when the department determines that:

- a. The provisions of 441—paragraph 130.5(2) “a,” “b,” “c,” “d,” “g,” or “h” apply.
- b. The client receives care in a hospital or nursing facility for 120 days in any one stay for purposes other than respite care.
- c. The client receives elderly waiver services and the physical or mental condition of the client requires more care than can be provided in the client’s own home as determined by the case manager and the interdisciplinary team.
- d. Service providers are not available.

83.28(3) Reduction. Reduction of services will apply as specified in 441—paragraphs 130.5(3) “a” and “b.”

[ARC 0318D, IAB 5/27/26, effective 7/1/26]

441—83.29(249A) Appeal rights. Notice of adverse action will be given in accordance with rule 441—16.2(17A). The right to appeal shall be given in accordance with 441—Chapter 2506.

[ARC 0318D, IAB 5/27/26, effective 7/1/26]

441—83.30(249A) Enhanced services. When a household has one person receiving service in accordance with rules set forth in 441—Chapter 24 and another receiving elderly waiver services, the persons providing case management will cooperate to make the best plan for both clients. When a person is eligible for services as set forth in 441—Chapter 24 and eligible for services under the elderly waiver, the person’s primary diagnosis will determine which services will be used.

[ARC 0318D, IAB 5/27/26, effective 7/1/26]

441—83.31 to 83.40 Reserved.

These rules are intended to implement Iowa Code sections 249A.3 and 249A.4.

DIVISION III—HCBS AIDS/HIV WAIVER SERVICES

441—83.41(249A) Definitions.

“*AIDS*” means a medical diagnosis of acquired immunodeficiency syndrome based on the Centers for Disease Control “Revision of the CDC Surveillance Case Definition for Acquired Immunodeficiency Syndrome,” August 14, 1987, Vol. 36, No. 1S issue of “Morbidity and Mortality Weekly Report.”

“*Basic individual respite*” means respite provided on a staff-to-member ratio of one to one or higher to individuals without specialized needs requiring the care of a licensed registered nurse or licensed practical nurse.

“*Case management*” means the categories of case management: targeted case management, case management provided to members enrolled in a 1915(c) waiver, and community-based case management provided through managed care.

“*Case manager*” means the staff person providing all categories of case management services regardless of the entity providing the services or the program in which the member is enrolled.

“*Client participation*” means the amount of the recipient’s income that the person must contribute to the cost of AIDS/HIV waiver services exclusive of medical vendor payments before Medicaid will participate.

“Deeming” means the specified amount of parental or spousal income and resources considered in determining eligibility for a child or spouse according to current supplemental security income guidelines.

“Financial participation” means client participation and medical payments from a third party including veterans’ aid and attendance.

“Guardian” means a guardian appointed in probate court.

“HIV” means a medical diagnosis of human immunodeficiency virus infection based on a positive HIV-related test.

“Managed care” means a system that provides the coordinated delivery of services and supports that are necessary and appropriate, delivered in the least restrictive settings and in the least intrusive manner. Managed care seeks to balance three factors:

1. Achieving high-quality outcomes for participants.
2. Coordinating access.
3. Containing costs.

“Managed care organization” or *“MCO”* means an entity that (1) is under contract with the department to provide services to Medicaid recipients and (2) meets the definition of “health maintenance organization” as defined in Iowa Code section 514B.1.

“Medical institution” means a nursing facility or hospital that has been approved as a Medicaid vendor.

“Member” means an individual who has been determined eligible and has been enrolled to receive Medicaid pursuant to rule 441—75.3(249A) or 441—75.6(249A), excluding medically needy, and is a recipient of waiver services.

“Nursing facility level of care” means that the following conditions are met:

1. The presence of a physical or mental impairment that restricts the member’s daily ability to perform the essential activities of daily living, bathing, dressing, and personal hygiene, and impedes the member’s capacity to live independently.
2. The member’s physical or mental impairment is such that self-execution of required nursing care is improbable or impossible.

“Service plan” means a person-centered, outcome-based plan of services that is written by the member’s case manager with input and direction from the member and that addresses all relevant services and supports being provided. The service plan is developed by the interdisciplinary team, which includes the member and, if appropriate, the member’s legal representative, member’s family, service providers, and others directly involved with the member.

“Skilled nursing facility level of care” means that the following conditions are met:

1. The member’s medical condition requires skilled nursing services or skilled rehabilitation services as defined in 42 CFR 409.31(a), 409.32, and 409.34 as amended to July 1, 2026.
2. Services are provided in accordance with the general provisions for all Medicaid providers and services as described in rule 441—79.10(249A).
3. Documentation submitted for review indicates that the member has:
 - A physician order for all skilled services.
 - Services that require the skills of medical personnel, including registered nurses, licensed practical nurses, physical therapists, occupational therapists, speech pathologists, or audiologists.
 - An individualized care plan that identifies support needs.
 - Confirmation that skilled services are provided to the member.
 - Skilled services that are provided by, or under the supervision of, medical personnel as described above.
 - Skilled nursing services that are needed and provided seven days a week or skilled rehabilitation services that are needed and provided at least five days a week.

“Third-party payment” means payment from an attorney, individual, institution, corporation, or public or private agency that is liable to pay part or all of the medical costs incurred as a result of

injury, disease or disability by or on behalf of an applicant or a past or present recipient of medical assistance.

“Usual caregiver” means a person or persons who reside with the member and are available on a 24-hour-per-day basis to assume responsibility for the care of the member.

[ARC 0318D, IAB 5/27/26, effective 7/1/26]

441—83.42(249A) Eligibility. To be eligible for AIDS/HIV waiver services a person must meet certain eligibility criteria and be determined to need a service(s) allowable under the program.

83.42(1) Eligibility criteria. All of the following criteria must be met. The person must:

a. Be diagnosed by a physician as having AIDS or HIV infection.

b. Be certified in need of the level of care that, but for the waiver, would otherwise be provided in a nursing facility or hospital based, in part, on information submitted on a completed information submission tool for children aged 3 and under, the interRAI - Pediatric Home Care (PEDS-HC) for those aged 4 to 20, or the interRAI - Home Care (HC) for those aged 21 and over and other supporting documentation as relevant. The information submission tool, the interRAI - PEDS-HC, and the interRAI - HC are available on request from the department. Copies of the completed information submission tool for an individual are available to that individual from the individual’s case manager or MCO.

(1) The assessment as listed in paragraph 83.42(1) “*b*” will be completed when the person applies for waiver services, upon request to report a significant change in the person’s condition, and annually for reassessment of the person’s level of care.

(2) The department will be responsible for approval of the certification of the level of care, and the department or an MCO will be responsible for annual redeterminations.

(3) AIDS/HIV waiver services will not be provided when the person is an inpatient in a medical institution.

c. Be eligible for medical assistance under supplemental security income (SSI), SSI-related, FMAP, or FMAP-related coverage groups; medically needy at hospital level of care; or a special income level (300 percent group); or become eligible through application of the institutional deeming rules.

d. Require, and use at least quarterly, one service available under the waiver as determined through an evaluation of need described in subrule 83.42(2).

e. Have service needs such that the costs of the waiver services are not likely to exceed the costs of care that would otherwise be provided in a medical institution.

f. Have income that does not exceed 300 percent of the maximum monthly payment for one person under supplemental security income.

g. For the consumer choices option as set forth in 441—subrule 78.38(9), not be living in a residential care facility.

83.42(2) Need for services.

a. The designated case manager will review the assessment of the person’s need for waiver services and determine the availability and appropriateness of services. This review will be based, in part, on information in the completed information submission tool designated in paragraph 83.42(1) “*b*” and other supporting documentation as relevant.

b. The total monthly cost of the AIDS/HIV waiver services will not exceed the established aggregate monthly cost for level of care. The monthly cost of AIDS/HIV waiver services cannot exceed the established limit of \$2,128.08.

[ARC 0318D, IAB 5/27/26, effective 7/1/26]

441—83.43(249A) Application.

83.43(1) Application for HCBS AIDS/HIV waiver services. The application process as specified in rules 441—76.1(249A) through 441—76.6(249A) shall be followed.

83.43(2) Approval of application.

a. Applications for the HCBS AIDS/HIV waiver program will be processed in 30 days unless one or more of the following conditions exist:

(1) The application is pending because the department has not received information that is beyond the control of the client or the department.

(2) The application is pending because a level of care determination has not been made although the completed assessment has been submitted to the department.

b. Decisions will be mailed or given to the applicant on the date when income maintenance eligibility and level of care determinations and the member service plan are completed.

c. An applicant must be given the choice between HCBS AIDS/HIV waiver services and institutional care. The applicant, parent, guardian, or attorney in fact under a durable power of attorney for health care shall sign the assessment and indicate that the applicant has elected home- and community-based services.

d. Waiver services provided prior to approval of eligibility for the waiver cannot be paid.

83.43(3) *Effective date of eligibility.*

a. The effective date of eligibility for the AIDS/HIV waiver for persons who are already determined eligible for Medicaid is the date on which the income and resource eligibility and level of care determinations are completed.

b. The effective date of eligibility for the AIDS/HIV waiver for persons who qualify for Medicaid due to eligibility for the waiver services and to whom 441—paragraph 75.6(4) “b” and rule 441—75.82(249A) do not apply is the date on which income and resource eligibility and level of care determinations are completed.

c. Eligibility for the waiver continues until the recipient has been in a medical institution for 120 consecutive days for other than respite care or fails to meet eligibility criteria listed in rule 441—83.42(249A). Recipients who are inpatients in a medical institution for 120 or more consecutive days for other than respite care will be reviewed for eligibility for other Medicaid coverage groups and terminated from AIDS/HIV waiver services if found eligible under another coverage group. The recipient will be notified of that decision through a notice of decision. If the member returns home before the effective date of the notice of decision and the person’s condition has not substantially changed, the denial may be rescinded and eligibility may continue.

d. The effective date of eligibility for the AIDS/HIV waiver for persons who qualify for Medicaid due to eligibility for the waiver services and to whom the eligibility factors set forth in 441—paragraph 75.6(4) “b” and, for married persons, in rule 441—75.82(249A) have been satisfied is the date on which the income eligibility and level of care determinations are completed but will not be earlier than the first of the month following the date of application.

83.43(4) *Attribution of resources.* For the purposes of attributing resources as provided in rule 441—75.82(249A), the date on which the waiver applicant met the level of care criteria in a medical institution as established by the peer review organization will be used as the date of entry to the medical institution. Only one attribution of resources will be completed per person. Attributions completed for prior institutionalizations will be applied to the waiver application.

[ARC 0318D, IAB 5/27/26, effective 7/1/26]

441—83.44(249A) Financial participation. Persons must contribute their predetermined financial participation to the cost of AIDS/HIV waiver services or other Medicaid services, as applicable.

83.44(1) *Maintenance needs of the individual.* The maintenance needs of the individual will be computed by deducting an amount that is 300 percent of the maximum monthly payment for one person under SSI from the client’s total income.

83.44(2) *Limitation on payment.* If the amount of the financial participation equals or exceeds the reimbursement established by the service worker for AIDS/HIV services, Medicaid will make no payments to AIDS/HIV waiver service providers. Medicaid will, however, make payments to other medical vendors.

[ARC 0318D, IAB 5/27/26, effective 7/1/26]

441—83.45(249A) Redetermination. A complete redetermination of eligibility for AIDS/HIV waiver services will be completed at least once every 12 months or when there is significant change in the person's situation or condition. A redetermination of continuing eligibility factors will be made in accordance with rules 441—76.17(249A) and 441—83.42(249A). A redetermination will include the components listed in rule 441—83.47(249A).

83.45(1) The department or the member's MCO will be responsible for annual redetermination of the level of care.

83.45(2) The MCO must submit documentation to the department for all reassessments, performed at least annually, that indicate a change in the member's level of care. The department will make a final determination for any reassessments that indicate a change in the level of care. If the level of care reassessment indicates no change in level of care, the member is approved to continue at the already established level of care.

[ARC 0318D, IAB 5/27/26, effective 7/1/26]

441—83.46(249A) Allowable services. Services allowable under the AIDS/HIV waiver are counseling, home health aide, homemaker, nursing care, respite care, home-delivered meals, adult day care, consumer-directed attendant care, financial management, independent support brokerage, self-directed personal care, self-directed community supports and employment, and individual-directed goods and services as set forth in rule 441—78.38(249A).

[ARC 0318D, IAB 5/27/26, effective 7/1/26]

441—83.47(249A) Service plan. A service plan will be prepared for AIDS/HIV waiver members in accordance with rule 441—130.7(234) except that service plans for both children and adults will be completed every 12 months or when there is significant change in the person's situation or condition.

83.47(1) The service plan will include the frequency of the AIDS/HIV waiver services and the types of providers who will deliver the services.

83.47(2) The service plan will indicate whether the member has elected the consumer choices option. If the member has elected the consumer choices option, the service plan will identify:

- a. The independent support broker selected by the member; and
- b. The financial management service selected by the member.

83.47(3) Service plans for members aged 20 or under must be developed to reflect use of all appropriate nonwaiver Medicaid services so as not to replace or duplicate those services.

83.47(4) The service plan will identify a plan for emergencies and the supports available to the member in an emergency.

[ARC 0318D, IAB 5/27/26, effective 7/1/26]

441—83.48(249A) Adverse service actions.

83.48(1) Denial. An application for services will be denied when it is determined by the department that:

- a. The client is not eligible for or in need of services.
- b. Except for respite care, the AIDS/HIV waiver services are not needed on a regular basis.
- c. Service needs exceed the aggregate monthly costs established in paragraph 83.42(2) "b" or cannot be met by the services provided under the waiver.
- d. Needed services are not available from qualified providers.

83.48(2) Termination. Participation in the AIDS/HIV waiver program may be terminated when the department determines that:

- a. The provisions of 441—paragraph 130.5(2) "a," "b," "c," "d," "g," or "h" apply.
- b. The costs of the AIDS/HIV waiver services for the person exceed the aggregate monthly costs established in paragraph 83.42(2) "b."
- c. The client receives care in a hospital or nursing facility for 120 days or more in any one stay for purposes other than respite care.

d. The client receives AIDS/HIV waiver services and the physical or mental condition of the client requires more care than can be provided in the client's own home as determined by the service worker.

e. Service providers are not available.

83.48(3) Reduction. Reduction of services will apply as specified in 441—paragraphs 130.5(3) “a” and “b.”

[ARC 0318D, IAB 5/27/26, effective 7/1/26]

441—83.49(249A) Appeal rights. Notice of adverse action shall be given in accordance with rule 441—16.2(17A). The right to appeal shall be given in accordance with 441—Chapter 2506.

[ARC 0318D, IAB 5/27/26, effective 7/1/26]

441—83.50 to 83.59 Reserved.

These rules are intended to implement Iowa Code section 249A.4.

DIVISION IV—HCBS INTELLECTUAL DISABILITY WAIVER SERVICES

441—83.60(249A) Definitions.

“*Adaptive*” means age-appropriate skills related to taking care of one's self and one's ability to relate to others in daily living situations. These skills include limitations that occur in the areas of communication, self-care, home-living, social skills, community use, self-direction, safety, functional activities of daily living, leisure or work.

“*Adult*” means a person with an intellectual disability aged 18 or over.

“*Appropriate*” means that the services or supports or activities provided or undertaken by the organization are relevant to the member's needs, situation, problems, or desires.

“*Basic individual respite*” means respite provided on a staff-to-member ratio of one to one or higher to individuals without specialized needs requiring the care of a licensed registered nurse or licensed practical nurse.

“*Behavior*” means skills related to regulating one's own behavior including coping with demands from others, making choices, controlling impulses, conforming conduct to laws, and displaying appropriate sociosexual behavior.

“*Case management*” means the categories of case management: targeted case management, case management provided to members enrolled in a 1915(c) waiver, and community-based case management provided through managed care.

“*Case manager*” means the staff person providing all categories of case management services regardless of the entity providing the services or the program in which the member is enrolled.

“*Child*” means a person with an intellectual disability aged 17 or under.

“*Client participation*” means the posteligibility amount of the member's income that persons eligible through a special income level must contribute to the cost of the home and community-based waiver service.

“*Counseling*” means face-to-face mental health services provided to the member and caregiver by a QIDP to facilitate home management of the member and prevent institutionalization.

“*Deemed status*” means acceptance of certification or licensure of a program or service by another certifying body in place of certification based on review and evaluation.

“*Direct service*” means services involving face-to-face assistance to a member such as transporting a member or providing therapy.

“*DSM-5*” means the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, published by the American Psychiatric Association as amended to July 1, 2026.

“*Guardian*” means a guardian appointed in probate court.

“*Health*” means skills related to the maintenance of one's health including eating; illness identification, treatment and prevention; basic first aid; physical fitness; regular physical checkups and personal habits.

“Immediate jeopardy” means circumstances where the life, health, or safety of a person will be severely jeopardized if the circumstances are not immediately corrected.

“Intellectual disability” means a diagnosis of intellectual disability (intellectual developmental disorder), global developmental delay, or unspecified intellectual disability (intellectual developmental disorder) that will be made only when the onset of the person’s condition was during the developmental period and will be based on an assessment of the person’s intellectual functioning and level of adaptive skills. The diagnosis shall be made by a person who is a licensed psychologist or psychiatrist who is professionally trained to administer the tests required to assess intellectual functioning and to evaluate a person’s adaptive skills. The diagnosis shall be made in accordance with the criteria provided in DSM-5.

“Intermediate care facility for persons with an intellectual disability (ICF/ID)” means an institution that is primarily for the diagnosis, treatment, or rehabilitation of persons with an intellectual disability or persons with related conditions and that provides, in a protected residential setting, ongoing evaluation, planning, 24-hour supervision, coordination and integration of health or related services to help each person function at the greatest ability and is an approved Medicaid vendor.

“Intermediate care facility for persons with an intellectual disability level of care” means that the individual has a diagnosis of intellectual disability made in accordance with the criteria provided in DSM-5 or has a related condition as defined in 42 CFR 435.1009 as amended to July 1, 2026, and needs assistance in at least three of the following major life areas: mobility, musculoskeletal skills, activities of daily living, domestic skills, toileting, eating skills, vision, hearing or speech or both, gross/fine motor skills, sensory-taste, smell, tactile, academic skills, vocational skills, social/community skills, behavior, and health care.

“Intermittent supported community living service” means supported community living service provided not more than 52 hours per month.

“Maintenance needs” means costs associated with rent or mortgage, utilities, telephone, food and household supplies.

“Managed care” means a system that provides the coordinated delivery of services and supports that are necessary and appropriate, delivered in the least restrictive settings and in the least intrusive manner. Managed care seeks to balance three factors:

1. Achieving high-quality outcomes for participants.
2. Coordinating access.
3. Containing costs.

“Managed care organization” or *“MCO”* means an entity that (1) is under contract with the department to provide services to Medicaid recipients and (2) meets the definition of “health maintenance organization” as defined in Iowa Code section 514B.1.

“Medical assessment” means a visual and physical inspection of the member, noting deviations from the norm, and a statement of the member’s mental and physical condition that can be amendable to or resolved by appropriate actions of the provider.

“Medical institution” means a nursing facility, intermediate care facility for persons with an intellectual disability, or hospital that has been approved as a Medicaid vendor.

“Medical intervention” means member care in the areas of hygiene, mental and physical comfort, assistance in feeding and elimination, and control of the member’s care and treatment to meet the physical and mental needs of the member in compliance with the plan of care in areas of health, prevention, restoration, and maintenance.

“Medical monitoring” means observation for the purpose of assessing, preventing, maintaining, and treating disease or illness based on the member’s plan of care.

“Member” means an individual who has been determined eligible and has been enrolled to receive Medicaid pursuant to rule 441—75.3(249A) or 441—75.6(249A), excluding medically needy, and is a recipient of waiver services.

“Organization” means the entity being certified.

“Outcome” means an action or event that follows as a result or consequence of the provision of a service or support.

“Procedures” means the steps to be taken to implement a policy.

“Process” means service or support provided by an agency to a member that will allow the member to achieve an outcome. This can include a written, formal, consistent trackable method or an informal process that is not written but is trackable.

“Program” means a set of related resources and services directed to the accomplishment of a fixed set of goals and objectives for the population of a specified geographic area or for special target populations. It can mean an agency, organization, or unit of an agency, organization or institution.

“Qualified intellectual disability professional” or *“QIDP”* means a person who has at least one year of experience working directly with persons with an intellectual disability or other developmental disabilities and who is one of the following:

1. A doctor of medicine or osteopathy.
2. A registered nurse.
3. An occupational therapist eligible for certification as an occupational therapist by the National Board for Certification in Occupational Therapy or another comparable body.
4. A physical therapist eligible for certification as a physical therapist by the American Physical Therapy Association or another comparable body.
5. A speech-language pathologist or audiologist eligible for certification of Clinical Competence in Speech-Language Pathology or Audiology by the American Speech-Language Hearing Association or another comparable body or who meets the educational requirements for certification and who is in the process of accumulating the supervised experience required for certification.
6. A psychologist with a master’s degree in psychology from an accredited school.
7. A social worker with a graduate degree from a school of social work, accredited or approved by the Council on Social Work Education or another comparable body or who holds a bachelor of social work degree from a college or university accredited or approved by the Council of Social Work Education or another comparable body.
8. A professional recreation staff member with a bachelor’s degree in recreation or in a specialty area such as art, dance, music or physical education.
9. A professional dietitian who is eligible for registration by the Academy of Nutrition and Dietetics.
10. A human services professional who must have at least a bachelor’s degree in a human services field, including but not limited to sociology, special education, rehabilitation counseling and psychology.

“Related condition” means a severe, chronic disability that meets all the following conditions:

1. It is attributable to cerebral palsy, epilepsy, or any other condition, other than mental illness, found to be closely related to intellectual disability because the condition results in impairment of general intellectual functioning or adaptive behavior similar to that of a person with an intellectual disability and requires treatment or services similar to those required for a person with an intellectual disability.

2. It is manifested before the age of 22.

3. It is likely to continue indefinitely.

4. It results in substantial functional limitations in three or more of the following areas of major life activity:

- Self-care.
- Understanding and use of language.
- Learning.
- Mobility.
- Self-direction.
- Capacity for independent living.

“*Service plan*” means a person-centered, outcome-based plan of services that is written by the member’s case manager with input and direction from the member and that addresses all relevant services and supports being provided. The service plan is developed by the interdisciplinary team, which includes the member and, if appropriate, the member’s legal representative, member’s family, service providers, and others directly involved with the member.

“*Staff*” means a person under the direction of the organization to perform duties and responsibilities of the organization.

“*Third-party payment*” means payment from an attorney, individual, institution, corporation, insurance company, or public or private agency that is liable to pay part or all of the medical costs incurred as a result of injury, disease or disability by or on behalf of an applicant or a past or present recipient of Medicaid.

“*Usual caregiver*” means a person or persons who reside with the member and are available on a 24-hour-per-day basis to assume responsibility for the care of the member.

[ARC 0318D, IAB 5/27/26, effective 7/1/26]

441—83.61(249A) Eligibility. To be eligible for HCBS intellectual disability waiver services, a person must meet certain eligibility criteria and be determined to need a service(s) available under the program.

83.61(1) Eligibility criteria. All of the following criteria must be met. The person must:

a. Have a diagnosis of intellectual disability as defined in rule 441—83.60(249A). The diagnosis shall be initially established and recertified as follows:

Age	Initial application to HCBS intellectual disability waiver program	Recertification for persons with a diagnosis of moderate, severe or profound level of severity	Recertification for persons with a diagnosis of mild or unspecified level of severity
0 through 17 years	Psychological documentation within three years of the application date substantiating a diagnosis of intellectual disability as defined in rule 441—83.60(249A)	After the initial psychological evaluation, substantiate a diagnosis of intellectual disability as defined in rule 441—83.60(249A) every six years and when a significant change occurs	After the initial psychological evaluation, substantiate a diagnosis of intellectual disability as defined in rule 441—83.60(249A) every three years and when a significant change occurs
18 years and above	Current psychological documentation substantiating a diagnosis of intellectual disability if the last testing date was (1) more than six years ago for an applicant with a diagnosis of mild or unspecified severity, or (2) more than ten years ago for an applicant with a diagnosis of moderate, severe or profound level of severity	Psychological documentation substantiating a diagnosis of intellectual disability made since the member reached 22 years of age	Psychological documentation substantiating a diagnosis of intellectual disability every six years and whenever a significant change occurs

b. Be eligible for Medicaid under supplemental security income (SSI), SSI-related, FMAP, or FMAP-related coverage groups; eligible under the special income level (300 percent) coverage group; or become eligible through application of the institutional deeming rules or would be eligible for Medicaid if in a medical institution.

c. Be certified as being in need for long-term care that, but for the waiver, would otherwise be provided in an ICF/ID. The department will be responsible for the initial approval, and the department or an MCO will be responsible for the annual approval of the certification of the level of care based on the data collected by the case manager and interdisciplinary team on a tool designated by the department.

d. Be a recipient of the Medicaid case management services or be identified to receive Medicaid case management services immediately following program enrollment.

e. Have service needs that can be met by this waiver program. At a minimum, a member must receive one billable unit of service per calendar quarter under this program.

f. Have a service plan completed annually and approved by the department in accordance with rule 441—83.67(249A).

g. For individual supported employment and long-term job coaching services:

(1) Be at least 16 years of age.

(2) The services must not be available to the member through one of the following:

1. Special education and related services as defined in the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.) as amended to July 1, 2026; or

2. A program funded under Section 110 of the Rehabilitation Act of 1973 (29 U.S.C. 730) as amended to July 1, 2026.

(3) Not reside in a medical institution.

(4) Have documented in the waiver service plan a goal to achieve or to sustain individual employment.

h. For small-group supported employment services:

(1) Be at least 16 years of age.

(2) The services must not be available to the member through one of the following:

1. Special education and related services as defined in the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.) as amended to July 1, 2026; or

2. A program funded under Section 110 of the Rehabilitation Act of 1973 (29 U.S.C. 730) as amended to July 1, 2026.

(3) Have documented in the waiver service plan a goal to achieve or to sustain individual employment.

(4) Have documented in the waiver service plan that the choice to receive individual supported employment services was offered and explained in a manner sufficient to ensure informed choice, after which the choice to receive small-group supported employment services was made.

(5) Not reside in a medical institution.

i. For prevocational services:

(1) Be at least 16 years of age.

(2) The services must not be available to the member through one of the following:

1. Special education and related services as defined in the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.) as amended to July 1, 2026; or

2. A program funded under Section 110 of the Rehabilitation Act of 1973 (29 U.S.C. 730) as amended to July 1, 2026.

(3) Have documented in the waiver service plan a goal to achieve or to sustain individual employment.

(4) Have documented in the waiver service plan that the choice to receive individual supported employment services was offered and explained in a manner sufficient to ensure informed choice, after which the choice to receive small-group supported employment services was made.

(5) Not reside in a medical institution.

j. Choose HCBS intellectual disability waiver services rather than ICF/ID services.

k. To be eligible for interim medical monitoring and treatment services the member must be:

(1) Under the age of 21;

(2) Currently receiving home health agency services under rule 441—78.9(249A) and require medical assessment, medical monitoring, and regular medical intervention or intervention in a medical emergency during those services. (The home health aide services for which the member is eligible must be maximized before the member accesses interim medical monitoring and treatment.);

(3) Residing in the member's family home or foster family home; and

(4) In need of interim medical monitoring and treatment as ordered by a physician, nurse practitioner, clinical nurse specialist, or physician associate.

l. Be assigned an HCBS intellectual disability payment slot pursuant to subrule 83.61(4).

m. For residential-based supported community living services, meet all of the following additional criteria:

(1) Be less than 18 years of age.
(2) Be preapproved as appropriate for residential-based supported community living services by the department. Requests for approval shall be submitted in writing to the department and shall include the following:

1. Social history;
2. Case history that includes previous placements and service programs;
3. Medical history that includes major illnesses and current medications;
4. Current psychological evaluations and consultations;
5. Summary of all reasonable and appropriate service alternatives that have been tried or considered;
6. Any current court orders in effect regarding the child;
7. Any legal history;
8. Whether the child is at risk of out-of-home placement or the proposed placement would be less restrictive than the child's current placement for services;
9. Whether the proposed placement would be safe for the child and for other children living in that setting; and
10. Whether the interdisciplinary team is in agreement with the proposed placement.

(3) Either:
1. Be residing in an ICF/ID;
2. Be at risk of ICF/ID placement, as documented by an interdisciplinary team assessment pursuant to paragraph 83.61(2) "a"; or

3. Be a child whose long-term placement outside the home is necessary because continued stay in the home would be a detriment to the health and welfare of the child or the family, and all service options to keep the child in the home have been reviewed by an interdisciplinary team, as documented in the service file.

- n.* For day habilitation, be 16 years of age or older.
- o.* For the consumer choices option as set forth in 441—subrule 78.41(15), not be living in a residential care facility.

83.61(2) *Need for services.*

a. Applicants currently receiving Medicaid case management shall have the applicable staff coordinate with the department to arrange completion of the interRAI assessment tool.

b. Applicants not receiving services as set forth in paragraph 83.61(2) "a" shall have a department service worker or case manager:

(1) Arrange for completion of the interRAI assessment tool for the initial level of care determination;

(2) Establish an initial interdisciplinary team for HCBS intellectual disability waiver services; and

(3) With the initial interdisciplinary team, identify the applicant's needs and desires as well as the availability and appropriateness of services.

c. Applicants meeting other eligibility criteria who do not have a Medicaid case manager will be referred to a Medicaid case manager.

d. Services will not exceed the number of maximum units established for each service.

e. The cost of services shall not exceed unit expense maximums. Requests will only be reviewed for funding needs exceeding the supported community living service unit cost maximum. Requests require special review by the department and may be denied as not cost-effective.

f. The case manager shall coordinate with the department for completion of an interRAI assessment tool for the initial level of care determination within 30 days from the date of the HCBS application unless the case manager can document difficulty in locating information necessary to arrange the assessment or other circumstances beyond the case manager's control.

g. At initial enrollment, the case manager will establish an interdisciplinary team for each applicant and, with the team, identify the applicant's need for service based on the applicant's needs

and desires as well as the availability and appropriateness of services. The Medicaid case manager will complete an annual review thereafter. The following criteria will be used for the initial and ongoing identification of need for services:

(1) The assessment will be based on the results of the most recent interRAI assessment or the off-year assessment tool.

(2) Service plans must be developed or reviewed to reflect use of all appropriate nonwaiver Medicaid services so as not to replace or duplicate those services.

(3) Service plans for applicants aged 16 or under which include supported community living services beyond intermittent will be approved (signed and dated) by the department. The service worker, department QIDP, or Medicaid case manager will attach a written request for a variance from the maximum for intermittent supported community living with a summary of services and service costs. The written request for the variance will provide a rationale for requesting supported community living beyond intermittent. The rationale will contain sufficient information for the designee to make a decision regarding the need for supported community living beyond intermittent.

h. Interim medical monitoring and treatment services must be needed because all usual caregivers are unavailable to provide care due to one of the following circumstances:

(1) Employment. Interim medical monitoring and treatment services are to be received only during hours of employment.

(2) Academic or vocational training. Interim medical monitoring and treatment services provided while a usual caregiver participates in postsecondary education or vocational training shall be limited to 24 periods of no more than 30 days each per caregiver as documented by the service worker. Time spent in high school completion, adult basic education, GED, or English as a second language does not count toward the limit.

(3) Absence from the home due to hospitalization, treatment for physical or mental illness, or death of the usual caregiver. Interim medical monitoring and treatment services under this subparagraph are limited to a maximum of 30 days.

(4) Search for employment.

1. Care during job search shall be limited to only those hours the usual caregiver is actually looking for employment, including travel time.

2. Interim medical monitoring and treatment services may be provided under this paragraph only during the execution of one job search plan of up to 30 working days in a 12-month period, approved by the department service worker or targeted case manager pursuant to 441—subparagraph 170.2(2) “b”(5).

3. Documentation of job search contacts shall be furnished to the department service worker or targeted case manager.

83.61(3) *HCBS intellectual disability waiver program limit.* The number of persons receiving HCBS intellectual disability waiver services in the state will be limited to the number of payment slots provided in the HCBS intellectual disability waiver approved by the Centers for Medicare and Medicaid Services (CMS). The department will make a request to CMS to adjust the program limit as deemed necessary.

a. The payment slots are available on a statewide basis. These slots will be available based on the prioritized need of an applicant pursuant to subrule 83.61(4).

b. When services are denied because the limit is reached, a notice of decision denying service based on the limit and stating that the person’s name will be put on a waiting list will be sent to the person by the department.

83.61(4) *Securing a payment slot.* The department will determine whether a payment slot is available for each applicant for the HCBS intellectual disability waiver.

a. A payment slot will be assigned to the applicant upon confirmation of an available slot.

(1) Once a payment slot is assigned, the department will give written notice to the applicant.

(2) The department will hold the payment slot for the applicant as long as reasonable efforts are being made to arrange services and the applicant has not been determined to be ineligible for the

program. If services have not been initiated and reasonable efforts are no longer being made to arrange services, the slot will revert for use by the next person on the waiting list, if applicable. The applicant originally assigned the slot must reapply for a new slot.

b. If no payment slot is available, the applicant will be placed on a statewide priority waiting list. The department will assess each applicant to determine the applicant's priority need. The assessment shall be made for all applicants who are on a waiting list maintained by the state or a county.

(1) Emergency need criteria are as follows:

1. The usual caregiver has died or is incapable of providing care, and no other caregivers are available to provide needed supports.

2. The applicant has lost primary residence or will be losing housing within 30 days and has no other housing options available.

3. The applicant is living in a homeless shelter and no alternative housing options are available.

4. There is founded abuse or neglect by a caregiver or others living within the home of the applicant, and the applicant must move from the home.

5. The applicant cannot meet basic health and safety needs without immediate supports.

(2) Urgent need criteria are as follows:

1. The caregiver will need support within 60 days in order for the applicant to remain living in the current situation.

2. The caregiver will be unable to continue to provide care within the next 60 days.

3. The caregiver is 55 years of age or older and has a chronic or long-term physical or psychological condition that limits the ability to provide care.

4. The applicant is living in temporary housing and plans to move within 31 to 120 days.

5. The applicant is losing permanent housing and plans to move within 31 to 120 days.

6. The caregiver will be unable to be employed if services are not available.

7. There is a potential risk of abuse or neglect by a caregiver or others within the home of the applicant.

8. The applicant has behaviors that put the applicant at risk.

9. The applicant has behaviors that put others at risk.

10. The applicant is at risk of facility placement when needs could be met through community-based services.

(3) Applicants who meet an emergency need criterion will be placed on the priority waiting list based on the total number of criteria in subparagraph 83.61(4)“b”(1) that are met. If applicants meet an equal number of criteria, the position on the waiting list will be based on the date of application and the age of the applicant. The applicant who has been on the waiting list longer will be placed higher on the waiting list. If the application date is the same, the older applicant will be placed higher on the waiting list.

(4) Applicants who meet an urgent need criterion will be placed on the priority waiting list after applicants who meet emergency need criteria. The position on the waiting list will be based on the total number of criteria in subparagraph 83.61(4)“b”(2) that are met. If applicants meet an equal number of criteria, the position on the waiting list will be based on the date of application and the age of the applicant. The applicant who has been on the waiting list longer will be placed higher on the waiting list. If the application date is the same, the older applicant will be placed higher on the waiting list.

(5) Applicants who do not meet emergency or urgent need criteria will be placed lower on the waiting list than the applicants meeting urgent need criteria, based on the date of application. If the application date is the same, the older applicant will be placed higher on the waiting list.

(6) Applicants will remain on the waiting list until a payment slot has been assigned to them for use, they withdraw from the list, or they become ineligible for the waiver. If there is a change in an applicant's need, the applicant may contact the local department office and request that a new

assessment be completed. The outcome of the assessment will determine placement on the waiting list as directed in this subrule.

c. To maintain the approved number of members in the program, persons will be selected from the waiting list as payment slots become available, based on their priority order on the waiting list.

(1) Once a payment slot is assigned, the department will give written notice to the person within five working days.

(2) The department will hold the payment slot for 30 days for the person to file a new application. If an application has not been filed within 30 days, the slot will revert for use by the next person on the waiting list, if applicable. The person originally assigned the slot must reapply for a new slot.

d. The state reserves payment slots each waiver year (July 1 to June 30) for use by children who must reside outside the family home in a residential-based supported community living licensed residential care facility. The state also reserves payment slots each waiver year (July 1 to June 30) for use by members living in an ICF/ID, nursing facility, or out-of-state placement, or transitioning from the Money Follows the Person Grant, who choose to access services in the intellectual disability waiver program and leave the ICF/ID, nursing facility, or out-of-state placement to live in the community.

(1) Applicants who currently reside in an ICF/ID or nursing facility and have resided in that setting for four or more months may request a reserved capacity slot through the intellectual disability waiver.

(2) Applicants will be allocated a reserved capacity slot on the basis of the date the request is received by the income maintenance worker or the waiver slot manager.

(3) In the event that more than one request for a reserved capacity slot is received at one time, applicants will be allocated the next available reserved capacity slot on the basis of the month of birth, January being month one and the lowest number.

(4) Persons who do not fall within the available reserved capacity slots will have the person's name maintained on the reserved capacity slot waiting list. As reserved capacity slots become available at the beginning of the next waiver year, persons will be selected from the reserved capacity slot waiting list to utilize the number of approved reserved capacity slots based on the person's order on the waiting list.

[ARC 0318D, IAB 5/27/26, effective 7/1/26]

441—83.62(249A) Application.

83.62(1) *Application for HCBS intellectual disability waiver services.* The application process as specified in rules 441—76.1(249A) through 441—76.6(249A) will be followed.

83.62(2) *Approval of application.*

a. Applications for the HCBS intellectual disability waiver program will be processed in 30 days unless the case manager or worker can document difficulty in locating and arranging services or other circumstance beyond the worker's control. In these cases a decision will be made as soon as possible.

b. Decisions will be mailed or given to the applicant on the date when both service and income maintenance eligibility determinations are completed.

c. An applicant will be given the choice between HCBS waiver services and ICF/ID care. The case manager or worker will have the member or legal representative indicate the member's choice of care.

d. HCBS intellectual disability waiver services provided before eligibility for the waiver is approved will not be reimbursed by the HCBS waiver program.

e. Services provided when the person is a member of group foster care services or is an inpatient in a medical institution will not be reimbursed.

f. HCBS intellectual disability waiver services are not available in conjunction with other Medicaid waiver services or group foster care services.

83.62(3) *Effective date of eligibility.*

a. Deeming of parental income and resources ceases the month following the month in which a person requires care in a medical institution.

b. The effective date of eligibility for the waiver for persons who are already determined eligible for Medicaid is the date on which the person is determined to meet the criteria set forth in rule 441—83.61(249A).

c. The effective date of eligibility for the waiver for persons who qualify for Medicaid due to eligibility for the waiver services is the date on which the person is determined to meet criteria set forth in rule 441—83.61(249A) and when the eligibility factor set forth in 441—paragraph 75.6(4) “*b*” and, for married persons, in rule 441—75.82(249A) have been satisfied.

d. Eligibility continues until the member fails to meet eligibility criteria listed in rule 441—83.61(249A). Members who are inpatients in a medical institution for 120 consecutive days will receive a review by the interdisciplinary team to determine additional inpatient needs for possible termination from the HCBS program. Members will be reviewed for eligibility under other Medicaid coverage groups. The member or legal representative will participate in the review and receive formal notification of that decision through a notice of decision.

If the member returns home before the effective date of the notice of decision and the member’s needs can still be met by the HCBS waiver services, the denial may be rescinded and eligibility may continue.

e. Eligibility and service reimbursement are effective through the last day of the month of the previous annual service plan staffing meeting and the corresponding long-term care need determination.

83.62(4) *Attribution of resources.* For the purposes of attributing resources as provided in rule 441—75.82(249A), the date on which the waiver applicant met the level of care criteria in a medical institution as established by the peer review organization will be used as the date of entry to the medical institution. Only one attribution of resources will be completed per person. Attributions completed for prior institutionalizations will be applied to the waiver application.

[ARC 0318D, IAB 5/27/26, effective 7/1/26]

441—83.63(249A) Client participation. Persons who are eligible under the 300 percent group must contribute a predetermined client participation amount to the costs of the services.

83.63(1) *Computation of client participation.* Client participation will be computed by deducting an amount for the maintenance needs of the individual that is 300 percent of the maximum SSI grant for an individual from the client’s total income.

83.63(2) *Limitation on payment.* If the sum of the third-party payment and client participation equals or exceeds the reimbursement for the specific HCBS waiver service, Medicaid will make no payments for the HCBS waiver service. However, Medicaid will make payments to other medical vendors.

[ARC 0318D, IAB 5/27/26, effective 7/1/26]

441—83.64(249A) Redetermination. A redetermination of nonfinancial eligibility for HCBS intellectual disability waiver services will be completed at least once every 12 months. In years in which an interRAI assessment is not completed, the core standardized assessment contractor shall conduct a review in collaboration with the case manager, documenting any changes in the member’s functional status since the previous interRAI or other full assessment. An information assessment tool will be completed annually for children under the age of six. A redetermination of continuing eligibility factors will be made when a change in circumstances occurs that affects eligibility in accordance with rule 441—83.61(249A).

83.64(1) The department or the member’s MCO will be responsible for annual redetermination of the level of care.

83.64(2) The MCO must submit documentation to the department for all reassessments, performed at least annually, that indicate a change in the member’s level of care. The department

will make a final determination for any reassessments that indicate a change in the level of care. If the level of care reassessment indicates no change in level of care, the member is approved to continue at the already established level of care.

[ARC 0318D, IAB 5/27/26, effective 7/1/26]

441—83.65 Reserved.

441—83.66(249A) Allowable services. Services allowable under the HCBS intellectual disability waiver are supported community living, respite, personal emergency response system, nursing, home health aide, home and vehicle modification, supported employment, consumer-directed attendant care, interim medical monitoring and treatment, transportation, adult day care, day habilitation, prevocational services, financial management, independent support brokerage, self-directed personal care, self-directed community supports and employment, and individual-directed goods and services as set forth in rule 441—78.41(249A).

[ARC 0318D, IAB 5/27/26, effective 7/1/26]

441—83.67(249A) Service plan. A service plan will be prepared for each HCBS intellectual disability waiver member.

83.67(1) Development. The service plan will be developed by the interdisciplinary team that includes the member, and, if appropriate, the legal representative, member's family, case manager or service worker, service providers, and others directly involved.

83.67(2) Retention. The service plan will be stored by the case manager for a minimum of three years.

83.67(3) Interdisciplinary team meeting. The interdisciplinary team meeting will be conducted before the current service plan expires.

83.67(4) Information in plan. The plan will be in accordance with 441—subrule 24.4(3) and will additionally include the following information to assist in evaluating the program:

- a. A listing of all services received by a member at the time of waiver program enrollment.
- b. For supported community living:
 - (1) The member's living environment at the time of waiver enrollment.
 - (2) The number of hours per day of on-site staff supervision needed by the member.
 - (3) The number of other waiver members who will live with the member in the living unit.
- c. An identification and justification of any restriction of the member's rights, including but not limited to:
 - (1) Maintenance of personal funds.
 - (2) Self-administration of medications.
- d. The name of the service provider responsible for providing each service.
- e. The service funding source.
- f. The amount of the service to be received by the member.
- g. Whether the member has elected the consumer choices option and, if so:
 - (1) The independent support broker selected by the member; and
 - (2) The financial management service selected by the member.
- h. A plan for emergencies and identification of the supports available to the member in an emergency.
- i. For members receiving daily supported community living, day habilitation, or adult day care, the assignment to acuity tiers is based on a mathematically valid process that identifies meaningful differences in the support needs of the members based on the interRAI-ID and ChYMH-DD scores.

83.67(5) Documentation. The Medicaid case manager will ensure that the member's case file contains the member's service plan and documentation supporting the diagnosis of intellectual disability.

83.67(6) *Approval of plan.* The plan will be approved through the institutional and waiver authorization and narrative system (IoWANS). Services shall be entered into IoWANS based on the service plan.

- a.* Services must be authorized and entered into IoWANS before the plan implementation date.
- b.* The department has 15 working days after receipt of the summary and service costs in which to approve the services and service cost or request modification of the service plan unless the parties mutually agree to extend that time frame.
- c.* If the department and the service worker or case manager are unable to agree on the terms of the services or service cost within ten days, the department has final authority regarding the services and service cost.

[ARC 0318D, IAB 5/27/26, effective 7/1/26]

441—83.68(249A) Adverse service actions.

83.68(1) *Denial.* An application for services will be denied when it is determined by the department that:

- a.* The applicant is not eligible for the services.
- b.* Service needs exceed the service unit or reimbursement maximums.
- c.* Service needs are not met by the services provided.
- d.* Needed services are not available or received from qualifying providers.
- e.* No HCBS intellectual disability waiver service is identified in the applicant's service plan.
- f.* There is another community resource available to provide the service or a similar service free of charge to the applicant that will meet the applicant's needs.
- g.* Completion or receipt of required documents by the department for the HCBS program applicant has not occurred.

83.68(2) *Reduction.* A particular service may be reduced when the department determines that the provisions of 441—paragraph 130.5(3) “a” or “b” apply.

83.68(3) *Termination.* A particular service may be terminated when the department determines that:

- a.* The provisions of 441—paragraph 130.5(2) “d,” “g,” or “h” apply.
- b.* Needed services are not available or received from qualifying providers.
- c.* No HCBS intellectual disability waiver service is identified in the member's annual service plan.
- d.* Service needs are not met by the services provided.
- e.* Services needed exceed the service unit or reimbursement maximums.
- f.* Completion or receipt of required documents by the department for the HCBS program member has not occurred.
- g.* The member receives services from other Medicaid waiver programs.
- h.* The member or legal representative through the interdisciplinary process requests termination from the services.

[ARC 0318D, IAB 5/27/26, effective 7/1/26]

441—83.69(249A) Appeal rights. Notice of adverse action will be given in accordance with rule 441—16.2(17A). The right to appeal shall be given in accordance with 441—Chapter 2506.

[ARC 0318D, IAB 5/27/26, effective 7/1/26]

441—83.70(249A) Rent subsidy program. Members in the HCBS intellectual disability waiver program may be eligible for a rent subsidy. More information can be found in 265—Chapter 24.

[ARC 0318D, IAB 5/27/26, effective 7/1/26]

441—83.71 to 83.80 Reserved.

These rules are intended to implement Iowa Code sections 249A.3 and 249A.4.

DIVISION V—BRAIN INJURY WAIVER SERVICES

441—83.81(249A) Definitions.

“Adaptive” means age-appropriate skills related to taking care of one’s self and the ability to relate to others in daily living situations. These skills include limitations that occur in the areas of communication, self-care, home living, social skills, community use, self-direction, safety, functional academics, leisure and work.

“Adult” means a person with a brain injury aged 18 years or over.

“Appropriate” means that the services or supports or activities provided or undertaken by the organization are relevant to the member’s needs, situation, problems, or desires.

“Assessment” means the review of the member’s current functioning in regard to the member’s situation, needs, strengths, abilities, desires and goals.

“Basic individual respite” means respite provided on a staff-to-member ratio of one to one or higher to individuals without specialized needs requiring the care of a licensed registered nurse or licensed practical nurse.

“Behavior” means skills related to regulating one’s own behavior including coping with demands from others, making choices, conforming conduct to laws, and displaying appropriate sociosexual behavior.

“Brain injury” or *“BI”* means clinically evident damage to the brain resulting directly or indirectly from trauma, infection, anoxia, vascular lesions or tumor of the brain, not primarily related to degenerative or aging processes, that temporarily or permanently impairs a person’s physical, cognitive, or behavioral functions. The person must have a diagnosis from the following list:

- Malignant neoplasms of brain, cerebrum.
- Malignant neoplasms of brain, frontal lobe.
- Malignant neoplasms of brain, temporal lobe.
- Malignant neoplasms of brain, parietal lobe.
- Malignant neoplasms of brain, occipital lobe.
- Malignant neoplasms of brain, ventricles.
- Malignant neoplasms of brain, cerebellum.
- Malignant neoplasms of brain, brain stem.
- Malignant neoplasms of brain, other part of brain, includes midbrain, peduncle, and medulla oblongata.
- Malignant neoplasms of brain, cerebral meninges.
- Malignant neoplasms of brain, cranial nerves.
- Secondary malignant neoplasm of brain.
- Secondary malignant neoplasm of other parts of the nervous system, includes cerebral meninges.
- Benign neoplasm of brain and other parts of the nervous system, brain.
- Benign neoplasm of brain and other parts of the nervous system, cranial nerves.
- Benign neoplasm of brain and other parts of the nervous system, cerebral meninges.
- Encephalitis, myelitis and encephalomyelitis.
- Intracranial and intraspinal abscess.
- Anoxic brain damage.
- Subarachnoid hemorrhage.
- Intracerebral hemorrhage.
- Other and unspecified intracranial hemorrhage.
- Occlusion and stenosis of precerebral arteries.
- Occlusion of cerebral arteries.
- Transient cerebral ischemia.
- Acute, but ill-defined, cerebrovascular disease.
- Other and ill-defined cerebrovascular diseases.

Fracture of vault of skull.
Fracture of base of skull.
Other and unqualified skull fractures.
Multiple fractures involving skull or face with other bones.
Concussion.
Cerebral laceration and contusion.
Cerebral edema.
Cerebral palsy.
Subarachnoid, subdural, and extradural hemorrhage following injury.
Other and unspecified intracranial hemorrhage following injury.
Intracranial injury of other and unspecified nature.
Poisoning by drugs, medicinal and biological substances.
Toxic effects of substances.
Effects of external causes.
Drowning and nonfatal submersion.
Asphyxiation and strangulation.
Child maltreatment syndrome.
Adult maltreatment syndrome.
Status epilepticus.

“*Child*” means a person with a brain injury aged 17 years or under.

“*Client participation*” means the amount of the member’s income that the person must contribute to the cost of brain injury waiver services, exclusive of medical vendor payments, before Medicaid will provide additional reimbursement.

“*Deemed status*” means acceptance of certification or licensure of a program or service by another certifying body in place of certification based on review and evaluation.

“*Direct service*” means services involving face-to-face assistance to a member such as transporting a member or providing therapy.

“*DSM-5*” means the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, published by the American Psychiatric Association as amended to July 1, 2026.

“*Guardian*” means a guardian appointed in probate court.

“*Health*” means skills related to the maintenance of one’s health including eating; illness identification, treatment and prevention; basic first aid; physical fitness; regular physical checkups and personal habits.

“*Immediate jeopardy*” means circumstances where the life, health, or safety of a person will be severely jeopardized if the circumstances are not immediately corrected.

“*Intermediate care facility for persons with an intellectual disability level of care*” means that the individual has a diagnosis of intellectual disability made in accordance with the criteria provided in DSM-5 or has a related condition as defined in 42 CFR 435.1009 as amended to July 1, 2026, and needs assistance in at least three of the following major life areas: mobility, musculoskeletal skills, activities of daily living, domestic skills, toileting, eating skills, vision, hearing or speech or both, gross/fine motor skills, sensory-taste, smell, tactile, academic skills, vocational skills, social/community skills, behavior, and health care.

“*Intermittent supported community living service*” means supported community living service provided from one to three hours a day for not more than four days a week.

“*Managed care*” means a system that provides the coordinated delivery of services and supports that are necessary and appropriate, delivered in the least restrictive settings and in the least intrusive manner. Managed care seeks to balance three factors:

1. Achieving high-quality outcomes for participants.
2. Coordinating access.
3. Containing costs.

“Managed care organization” or *“MCO”* means an entity that (1) is under contract with the department to provide services to Medicaid recipients and (2) meets the definition of “health maintenance organization” as defined in Iowa Code section 514B.1.

“Medical assessment” means a visual and physical inspection of the member, noting deviations from the norm, and a statement of the member’s mental and physical condition that can be amendable to or resolved by appropriate actions of the provider.

“Medical institution” means a nursing facility, a skilled nursing facility, intermediate care facility for persons with an intellectual disability, or hospital that has been approved as a Medicaid vendor.

“Medical intervention” means member care in the areas of hygiene, mental and physical comfort, assistance in feeding and elimination, and control of the member’s care and treatment to meet the physical and mental needs of the member in compliance with the plan of care in areas of health, prevention, restoration, and maintenance.

“Medical monitoring” means observation for the purpose of assessing, preventing, maintaining, and treating disease or illness based on the member’s plan of care.

“Nursing facility level of care” means that the following conditions are met:

1. The presence of a physical or mental impairment that restricts the member’s daily ability to perform the essential activities of daily living, bathing, dressing, and personal hygiene, and impedes the member’s capacity to live independently.
2. The member’s physical or mental impairment is such that self-execution of required nursing care is improbable or impossible.

“Organization” means the entity being certified.

“Outcome” means an action or event that follows as a result or consequence of the provision of a service or support.

“Procedures” means the steps to be taken to implement a policy.

“Process” means service or support provided by an agency to a member that will allow the member to achieve an outcome. This can include a written, formal, consistent trackable method or an informal process that is not written but is trackable.

“Program” means a set of related resources and services directed to the accomplishment of a fixed set of goals and objectives for the population of a specified geographic area or for special target populations. It can mean an agency, organization, or unit of an agency, organization or institution.

“Qualified brain injury professional” means one of the following who meets the educational and licensure or certification requirements for the profession as required in the state of Iowa and who has two years’ experience working with people living with a brain injury: a psychologist; psychiatrist; physician; physician associate; registered nurse; certified teacher; licensed clinical social worker; mental health counselor; physical, occupational, recreational, or speech therapist; or a person with a bachelor of arts or science degree in human services, social work, psychology, sociology, or public health or rehabilitation services plus 4,000 hours of direct experience with people living with a brain injury.

“Service coordination” means activities designed to help individuals and families locate, access, and coordinate a network of supports and services that will allow them to live a full life in the community.

“Service plan” means a person-centered, outcome-based plan of services that is written by the member’s case manager with input and direction from the member and that addresses all relevant services and supports being provided. The service plan is developed by the interdisciplinary team, which includes the member and, if appropriate, the member’s legal representative, member’s family, service providers, and others directly involved with the member.

“Skilled nursing facility level of care” means that the following conditions are met:

1. The member’s medical condition requires skilled nursing services or skilled rehabilitation services as defined in 42 CFR 409.31(a), 409.32, and 409.34 as amended to July 1, 2026.
2. Services are provided in accordance with the general provisions for all Medicaid providers and services as described in rule 441—79.10(249A).

3. Documentation submitted for review indicates that the member has:
 - A physician order for all skilled services.
 - Services that require the skills of medical personnel, including registered nurses, licensed practical nurses, physical therapists, occupational therapists, speech pathologists, or audiologists.
 - An individualized care plan that identifies support needs.
 - Confirmation that skilled services are provided to the member.
 - Skilled services that are provided by, or under the supervision of, medical personnel as described above.
 - Skilled nursing services that are needed and provided seven days a week or skilled rehabilitation services that are needed and provided at least five days a week.

“Staff” means a person under the direction of the organization to perform duties and responsibilities of the organization.

“Third-party payment” means payment from an individual, institution, corporation, or public or private provider that is liable to pay part or all of the medical costs incurred as a result of injury or disease on behalf of a member of medical assistance.

“Usual caregiver” means a person or persons who reside with the member and are available on a 24-hour-per-day basis to assume responsibility for the care of the member.

[ARC 0318D, IAB 5/27/26, effective 7/1/26]

441—83.82(249A) Eligibility. To be eligible for brain injury waiver services a member must meet eligibility criteria and be determined to need a service allowable under the program.

83.82(1) Eligibility criteria. All of the following criteria must be met. The person must:

- a. Have a diagnosis of brain injury.
- b. Be eligible for Medicaid under supplemental security income (SSI), SSI-related, FMAP, or FMAP-related coverage groups or be eligible under the special income level (300 percent) coverage group consistent with a level of care in a medical institution.
- c. Be at least one month of age.
- d. Be a U.S. citizen and Iowa resident.
- e. Reserved.
- f. Be determined by the department as in need of intermediate care facility for persons with an intellectual disability (ICF/ID), skilled nursing, or ICF level of care based on information submitted on a completed information submission tool for children aged 3 and under, the interRAI - Pediatric Home Care (PEDS-HC) for those aged 4 to 20, or the interRAI - Home Care (HC) for those aged 21 and over, the most recent version of the Mayo-Portland Adaptability Inventory (MPAI), and other supporting documentation as relevant. The information submission tool, the interRAI - PEDS-HC, and the interRAI - HC and the MPAI are available on request from the member’s MCO or the department. Copies of the completed information submission tool for an individual are available to that individual from the individual’s case manager or MCO.
- g. Be assessed by the department as able to live in a home- or community-based setting where all medically necessary service needs can be met within the scope of this waiver.
- h. At a minimum, receive a waiver service each quarter in addition to case management.
- i. Choose HCBS.
- j. To be eligible for interim medical monitoring and treatment services the member must be:
 - (1) Under the age of 21;
 - (2) Currently receiving home health agency services under rule 441—78.9(249A) and require medical assessment, medical monitoring, and regular medical intervention or intervention in a medical emergency during those services. (The home health aide services for which the member is eligible must be maximized before the member accesses interim medical monitoring and treatment.);
 - (3) Residing in the member’s family home or foster family home; and
 - (4) In need of interim medical monitoring and treatment as ordered by a physician, nurse practitioner, clinical nurse specialist, or physician associate.

- k.* Receive services in a community, not an institutional, setting.
- l.* Be assigned a state payment slot within the yearly total approved by the Centers for Medicare and Medicaid Services.
- m.* For the consumer choices option as set forth in 441—subrule 78.43(15), not be living in a residential care facility.
- n.* For individual supported employment and long-term job coaching services:
 - (1) Be at least 16 years of age.
 - (2) The services must not be available to the member through one of the following:
 - 1. Special education and related services as defined in the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.) as amended to July 1, 2026; or
 - 2. A program funded under Section 110 of the Rehabilitation Act of 1973 (29 U.S.C. 730) as amended to July 1, 2026.
 - (3) Not reside in a medical institution.
 - (4) Have documented in the waiver service plan a goal to achieve or to sustain individual employment and an expectation that this service will result in this outcome.
- o.* For small-group supported employment services:
 - (1) Be at least 16 years of age.
 - (2) The services must not be available to the member through one of the following:
 - 1. Special education and related services as defined in the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.) as amended to July 1, 2026; or
 - 2. A program funded under Section 110 of the Rehabilitation Act of 1973 (29 U.S.C. 730) as amended to July 1, 2026.
 - (3) Have documented in the waiver service plan a goal to achieve or to sustain individual employment.
 - (4) Have documented in the waiver service plan that the choice to receive individual supported employment services was offered and explained in a manner sufficient to ensure informed choice, after which the choice to receive small-group supported employment services was made.
- (5) Not reside in a medical institution.
- p.* For prevocational services:
 - (1) Be at least 16 years of age.
 - (2) The services must not be available to the member through one of the following:
 - 1. Special education and related services as defined in the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.) as amended to July 1, 2026; or
 - 2. A program funded under Section 110 of the Rehabilitation Act of 1973 (29 U.S.C. 730) as amended to July 1, 2026.
 - (3) Have documented in the waiver service plan a goal to achieve or to sustain individual employment and an expectation that this service will result in community employment.
 - (4) Have documented in the waiver service plan that the choice to receive individual supported employment services was offered and explained in a manner sufficient to ensure informed choice, after which the choice to receive prevocational services was made.

83.82(2) *Need for services.*

- a.* The applicant will have a service plan approved by the department that is developed by the Medicaid case manager for this waiver. This must be completed before services provision and annually thereafter. The case manager will establish the interdisciplinary team for the applicant and, with the team, identify the applicant's need for service based on the applicant's needs and desires as well as the availability and appropriateness of services using the following criteria:
 - (1) The assessment shall be based, in part, on information provided to the department.
 - (2) Service plans must be developed to reflect use of all appropriate nonwaiver Medicaid state plan services so as not to replace or duplicate those services.
 - (3) Service plans for applicants aged 16 or under that include supported community living services beyond intermittent must be approved (signed and dated) by the designee of the department.

The Medicaid case manager must request in writing more than intermittent supported community living with a summary of services and service costs, and submit a written justification with the service plan. The rationale must contain sufficient information for the department's designee to make a decision regarding the need for supported community living beyond intermittent.

b. Interim medical monitoring and treatment services must be needed because all usual caregivers are unavailable to provide care due to one of the following circumstances:

(1) Employment. Interim medical monitoring and treatment services are to be received only during hours of employment.

(2) Academic or vocational training. Interim medical monitoring and treatment services provided while a usual caregiver participates in postsecondary education or vocational training will be limited to 24 periods of no more than 30 days each per caregiver as documented by the service worker. Time spent in high school completion, adult basic education, GED, or English as a second language does not count toward the limit.

(3) Absence from the home due to hospitalization, treatment for physical or mental illness, or death of the usual caregiver. Interim medical monitoring and treatment services under this subparagraph are limited to a maximum of 30 days.

(4) Search for employment.

1. Care during job search shall be limited to only those hours the usual caregiver is actually looking for employment, including travel time.

2. Interim medical monitoring and treatment services may be provided under this paragraph only during the execution of one job search plan of up to 30 working days in a 12-month period, approved by the department service worker or targeted case manager pursuant to 441—subparagraph 170.2(2) “b”(5).

3. Documentation of job search contacts shall be furnished to the department service worker or targeted case manager.

c. The member shall access, if a child, all other services for which the person is eligible and that are appropriate to meet the person's needs as a precondition of eligibility for the HCBS BI waiver.

83.82(3) *Securing a state payment slot.*

a. The department field office will enter all waiver applications into the institutional and waiver authorization and narrative system (IoWANS) to determine whether a payment slot is available for all new applicants for the HCBS BI waiver program.

(1) For applicants not currently receiving Medicaid, the department field office will make the entry by the end of the fifth working day after receipt of a completed services application or within five working days after receipt of disability determination, whichever is later.

(2) For current Medicaid members, the department field office will make the entry by the end of the fifth working day after receipt of a written request signed and dated by the waiver applicant.

b. If no payment slot is available, the department will enter the applicant on a waiting list according to the following:

(1) Applicants not currently eligible for Medicaid will be entered on the waiting list on the basis of the date a completed health services application is received by the department or upon receipt of disability determination, whichever is later. Applicants currently eligible for Medicaid will be added to the waiting list on the basis of the date the applicant requests HCBS BI program services.

(2) In the event that more than one application is received at one time, applicants will be entered on the waiting list on the basis of the month of birth, January being month one and the lowest number.

c. Persons who do not fall within the available slots will have their applications rejected but their names will be maintained on the waiting list. As slots become available, persons will be selected from the waiting list to maintain the number of approved persons on the program based on their order on the waiting list.

d. Applicants who currently reside in a community-based neurobehavioral rehabilitation residential setting, an ICF/ID, a skilled nursing facility, or an ICF and have resided in that setting for four or more months may request a reserved capacity slot through the brain injury waiver.

(1) Applicants will be allocated a reserved capacity slot on the basis of the date the request is received by the income maintenance worker or the waiver slot manager.

(2) In the event that more than one request for a reserved capacity slot is received at one time, applicants will be allocated the next available reserved capacity slot on the basis of the month of birth, January being month one and the lowest number.

(3) Persons who do not fall within the available reserved capacity slots will have their names maintained on the reserved capacity slot waiting list. As reserved capacity slots become available at the beginning of the next waiver year, persons will be selected from the reserved capacity slot waiting list to utilize the number of approved reserved capacity slots based on their order on the waiting list.

e. The department will reserve a set number of funding slots each waiver year for emergency need for all applicants who are on the waiting list maintained by the state. Applicants may request an emergency need reserved capacity slot by submitting the completed home- and community-based services (HCBS) brain injury waiver emergency need assessment to the department.

(1) Emergency need criteria are as follows:

1. The usual caregiver has died or is incapable of providing care, and no other caregivers are available to provide needed supports.

2. The applicant has lost primary residence or will be losing housing within 30 days and has no other housing options available.

3. The applicant is living in a homeless shelter, and no alternative housing options are available.

4. There is founded abuse or neglect by a caregiver or others living within the home of the applicant, and the applicant must move from the home.

5. The applicant cannot meet basic health and safety needs without immediate supports.

(2) Urgent need criteria are as follows:

1. The caregiver will need support within 60 days in order for the applicant to remain living in the current situation.

2. The caregiver will be unable to continue to provide care within the next 60 days.

3. The caregiver is 55 years of age or older and has a chronic or long-term physical or psychological condition that limits the ability to provide care.

4. The applicant is living in temporary housing and plans to move within 31 to 120 days.

5. The applicant is losing permanent housing and plans to move within 31 to 120 days.

6. The caregiver will be unable to be employed if services are not available.

7. There is a potential risk of abuse or neglect by a caregiver or others within the home of the applicant.

8. The applicant has behaviors that put the applicant at risk.

9. The applicant has behaviors that put others at risk.

10. The applicant is at risk of facility placement when needs could be met through community-based services.

(3) Applicants who meet an emergency need criterion will be placed on the emergency reserved capacity priority waiting list based on the total number of criteria in subparagraph 83.82(3)“e”(1) that are met. If applicants meet an equal number of criteria, the position on the waiting list will be based on the date of application and the age of the applicant. The applicant who has been on the waiting list longer will be placed higher on the waiting list. If the application date is the same, the older applicant will be placed higher on the waiting list.

(4) Applicants who meet an urgent need criterion will be placed on the priority waiting list after applicants who meet emergency need criteria. The position on the waiting list will be based on the total number of criteria in subparagraph 83.82(3)“e”(2) that are met. If applicants meet an equal number of criteria, the position on the waiting list will be based on the date of application and the age of the applicant. The applicant who has been on the waiting list longer will be placed higher on the waiting list. If the application date is the same, the older applicant will be placed higher on the waiting list.

(5) Applicants who do not meet emergency or urgent need criteria will remain on the waiting list, based on the date of application. If the application date is the same, the older applicant will be placed higher on the waiting list.

(6) Applicants will remain on the waiting list until a payment slot has been assigned to them for use, they withdraw from the list, or they become ineligible for the waiver. If there is a change in an applicant's need, the applicant may contact the department and request that a new emergency needs assessment be completed. The outcome of the assessment will determine placement on the waiting list as directed in this subrule.

f. To maintain the approved number of members in the program, persons shall be selected from the waiting list as payment slots become available, based on their priority order on the waiting list.

(1) Once a payment slot is assigned, the department will give written notice to the person within five working days.

(2) The department will hold the payment slot for 30 days for the person to file a new application. If an application has not been filed within 30 days, the slot will revert for use by the next person on the waiting list, if applicable. The person originally assigned the slot must reapply for a new slot.

[ARC 0318D, IAB 5/27/26, effective 7/1/26]

441—83.83(249A) Application.

83.83(1) *Application for financial eligibility.* The application process as specified in rules 441—76.1(249A) through 441—76.6(249A) shall be followed.

83.83(2) *Approval of application for eligibility.*

a. Applications for the determination of ability of the member to have all medically necessary service needs met within the scope of this waiver will be initiated on behalf of the member and with the member's consent or with the consent of the member's legal representative by the discharge planner of the medical facility where the member resides at the time of application or the case manager. The discharge planner or case manager will provide to the department all appropriate information needed regarding all the medically necessary service needs of the member. After completing the determination of ability to have all medically necessary service needs met within the scope of this waiver, the department will inform the discharge planner or case manager on behalf of the member or the member's legal representative and send to the income maintenance worker a copy of the decision as to whether all of the member's service needs can be met in a home- or community-based setting.

b. Eligibility for the HCBS BI waiver will be effective as of the date when both the service eligibility and financial eligibility have been completed. Decisions will be mailed or given to the member or the member's legal representative on the date when each eligibility determination is completed.

c. An applicant will be given the choice between waiver services and institutional care. The applicant or legal representative will sign the applicable information submission tool listed in paragraph 83.82(1) "*f.*" indicating that the applicant has elected home- and community-based services. This will be arranged by the medical facility discharge planner or case manager.

d. The medical facility discharge planner, if there is one involved, will contact the member's MCO or the designated case manager to initiate development of the member's service plan and initiation of waiver services.

e. HCBS BI waiver services provided prior to both approvals of eligibility for the waiver cannot be paid.

f. HCBS BI waiver services are not available in conjunction with other HCBS waiver programs or group foster care services.

g. The Medicaid case manager will establish an HCBS BI waiver interdisciplinary team for each member and, with the team, identify the member's "need for service" based on the member's needs and desires as well as the availability and appropriateness of services.

83.83(3) Effective date of eligibility.

a. The effective date of eligibility for the waiver for persons who are already determined eligible for Medicaid is the date on which the person is determined to meet all of the criteria set forth in rule 441—83.82(249A).

b. The effective date of eligibility for the waiver for persons who qualify for Medicaid due to eligibility for the waiver services is the date on which the person is determined to meet all of the criteria set forth in rule 441—83.82(249A) and when the eligibility factors set forth in 441—paragraph 75.6(4) “b” and, for married persons, in rule 441—75.82(249A) have been satisfied.

c. Eligibility for the waiver continues until the member fails to meet eligibility criteria listed in rule 441—83.82(249A). Members who return to inpatient status in a medical institution for more than 120 consecutive days will be reviewed by the department to determine additional inpatient needs for possible termination from the brain injury waiver. The member will be reviewed for eligibility under other Medicaid coverage groups in accordance with rule 441—76.17(249A). The member will be notified of that decision through a notice of decision.

If the member returns home before the effective date of the notice of decision and the member’s condition has not substantially changed, the denial may be rescinded and eligibility may continue.

83.83(4) Attribution of resources. For the purposes of attributing resources as provided in rule 441—75.82(249A), the date on which the waiver member meets the level of care criteria in a medical institution as established by the peer review organization will be used as the date of entry to the medical institution. Only one attribution of resources will be completed per person. Attributions completed for prior institutionalizations will be applied to the waiver application.

[ARC 0318D, IAB 5/27/26, effective 7/1/26]

441—83.84(249A) Client participation. Members who are financially eligible under 441—paragraph 75.6(4) “b” (the 300 percent group) must contribute a predetermined participation amount to the cost of brain injury waiver services.

83.84(1) Computation of client participation. Client participation will be computed by deducting an amount for the maintenance needs of the member that is 300 percent of the maximum SSI grant for an individual from the member’s total income. For a couple, client participation is determined as if each person were an individual.

83.84(2) Limitation on payment. If the sum of the third-party payment and client participation equals or exceeds the reimbursement for the specific brain injury waiver service, Medicaid will make no payments for the waiver service. However, Medicaid will make payments to other medical providers.

[ARC 0318D, IAB 5/27/26, effective 7/1/26]

441—83.85(249A) Redetermination. A complete financial redetermination of eligibility for brain injury waiver will be completed at least once every 12 months. A redetermination of continuing eligibility factors will be made when a change in circumstances occurs that affects eligibility in accordance with rule 441—83.82(249A). A redetermination will contain the components listed in rule 441—83.82(249A).

[ARC 0318D, IAB 5/27/26, effective 7/1/26]

441—83.86(249A) Allowable services. Services allowable under the brain injury waiver are case management, respite, personal emergency response, supported community living, behavioral programming, family counseling and training, home and vehicle modification, specialized medical equipment, prevocational services, transportation, supported employment, adult day care, member-directed attendant care, interim medical monitoring and treatment, financial management, independent support brokerage, self-directed personal care, self-directed community supports and employment, and individual-directed goods and services as set forth in rule 441—78.43(249A).

[ARC 0318D, IAB 5/27/26, effective 7/1/26]

441—83.87(249A) Service plan. A service plan will be prepared and utilized for each HCBS BI waiver member. The service plan will be developed by an interdisciplinary team that includes the member, and, if appropriate, the legal representative, member's family, case manager, providers, and others directly involved. The service plan will be stored by the case manager for a minimum of three years. The service plan staffing will be conducted before the current service plan expires.

83.87(1) Information in plan. The plan will be in accordance with 441—subrule 24.4(3) and will additionally include the following information to assist in evaluating the program:

- a. A listing of all services received by a member at the time of waiver program enrollment.
- b. For supported community living:
 - (1) The member's living environment at the time of waiver enrollment.
 - (2) The number of hours per day of on-site staff supervision needed by the member.
 - (3) The number of other waiver members who will live with the member in the living unit.
- c. An identification and justification of any restriction of a member's rights, including but not limited to:
 - (1) Maintenance of personal funds.
 - (2) Self-administration of medications.
- d. The names of all providers responsible for providing all services.
- e. All service funding sources.
- f. The amount of the service to be received by the member.
- g. Whether the member has elected the member choices option and, if so:
 - (1) The independent support broker selected by the member; and
 - (2) The financial management service selected by the member.
- h. A plan for emergencies and identification of the supports available to the member in an emergency.

83.87(2) Use of nonwaiver services. Service plans must be developed to reflect use of all appropriate nonwaiver Medicaid services and so as not to replace or duplicate those services. Service plans for members aged 16 or under that include supported community living services beyond intermittent must be approved (signed and dated) by the designee of the department. The Medicaid case manager will attach a written request for a variance from the limitation on supported community living to intermittent.

83.87(3) Annual assessment. The department will assess the member annually and certify the member's need for long-term care services. The department will be responsible for determining the level of care based on the completed information submission tool listed in paragraph 83.82(1) "f" and other supporting documentation as relevant.

a. The department or the member's MCO will be responsible for annual redetermination of the level of care.

b. The MCO must submit documentation to the department for all reassessments, performed at least annually, that indicate a change in the member's level of care. The department will make a final determination for any reassessments that indicate a change in the level of care. If the level of care reassessment indicates no change in level of care, the member is approved to continue at the already established level of care.

83.87(4) Service file. The Medicaid case manager must ensure that the member service file contains the member's service plan.

[ARC 0318D, IAB 5/27/26, effective 7/1/26]

441—83.88(249A) Adverse service actions.

83.88(1) Denial. An application for services will be denied when it is determined by the department that:

- a. The member is not eligible for the services because all of the medically necessary service needs cannot be met in a home- or community-based setting.
- b. Service needs exceed the service unit or reimbursement maximums.

- c. Service needs are not met by the services provided.
- d. Needed services are not available or received from qualifying providers.
- e. The brain injury waiver service is not identified in the member's service plan.
- f. There is another community resource available to provide the service or a similar service free of charge to the member that will meet the member's needs.
- g. The member receives services from other Medicaid waiver providers.
- h. The member or legal representative through the interdisciplinary process requests termination from the services.

83.88(2) Reduction. A particular service may be reduced when the department determines that the provisions of 441—paragraph 130.5(3) “a” or “b” apply.

83.88(3) Termination. A particular service may be terminated when the department determines that:

- a. The provisions of 441—paragraph 130.5(2) “d,” “g,” or “h” apply.
- b. Needed services are not available or received from qualifying providers.
- c. The brain injury waiver service is not identified in the member's annual service plan.
- d. Service needs are not met by the services provided.
- e. Services needed exceed the service unit or reimbursement maximums.
- f. Completion or receipt of required documents by the department or the medical facility discharge planner for the brain injury waiver service member has not occurred.
- g. The member receives services from other Medicaid providers.
- h. The member or legal representative through the interdisciplinary process requests termination from the services.

[ARC 0318D, IAB 5/27/26, effective 7/1/26]

441—83.89(249A) Appeal rights. Notice of adverse action will be given in accordance with rule 441—16.2(17A). The right to appeal will be given in accordance with 441—Chapter 2506.

[ARC 0318D, IAB 5/27/26, effective 7/1/26]

441—83.90 to 83.100 Reserved.

These rules are intended to implement Iowa Code sections 249A.3 and 249A.4.

DIVISION VI—PHYSICAL DISABILITY WAIVER SERVICES

441—83.101(249A) Definitions.

“*Adaptive*” means age-appropriate skills related to taking care of one's self and the ability to relate to others in daily living situations. These skills include limitations that occur in the areas of communication, self-care, home living, social skills, community use, self-direction, safety, functional academics, leisure and work.

“*Adult*” means a person with a physical disability aged 18 years to 64 years.

“*Appropriate*” means that the services or supports or activities provided or undertaken by the organization are relevant to the member's needs, situation, problems, or desires.

“*Assessment*” means the review of the member's current functioning in regard to the member's situation, needs, strengths, abilities, desires and goals.

“*Behavior*” means skills related to regulating one's own behavior including coping with demands from others, making choices, controlling impulses, conforming conduct to laws, and displaying appropriate sociosexual behavior.

“*Client participation*” means the amount of the member's income that the person must contribute to the cost of physical disability waiver services, exclusive of medical vendor payments, before Medicaid will provide additional reimbursement.

“*DSM-5*” means the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, published by the American Psychiatric Association as amended to July 1, 2026.

“*Guardian*” means a guardian appointed in probate court for an adult.

“Intermediate care facility for persons with an intellectual disability level of care” means that the individual has a diagnosis of intellectual disability made in accordance with the criteria provided in DSM-5 or has a related condition as defined in 42 CFR 435.1009 as amended to July 1, 2026, and needs assistance in at least three of the following major life areas: mobility, musculoskeletal skills, activities of daily living, domestic skills, toileting, eating skills, vision, hearing or speech or both, gross/fine motor skills, sensory-taste, smell, tactile, academic skills, vocational skills, social/community skills, behavior, and health care.

“Managed care” means a system that provides the coordinated delivery of services and supports that are necessary and appropriate, delivered in the least restrictive settings and in the least intrusive manner. Managed care seeks to balance three factors:

1. Achieving high-quality outcomes for participants.
2. Coordinating access.
3. Containing costs.

“Managed care organization” or *“MCO”* means an entity that (1) is under contract with the department to provide services to Medicaid recipients and (2) meets the definition of “health maintenance organization” as defined in Iowa Code section 514B.1.

“Medical institution” means a nursing facility, a skilled nursing facility, intermediate care facility for persons with an intellectual disability, or hospital that has been approved as a Medicaid vendor.

“Nursing facility level of care” means that the following conditions are met:

1. The presence of a physical or mental impairment that restricts the member’s daily ability to perform the essential activities of daily living, bathing, dressing, and personal hygiene, and impedes the member’s capacity to live independently.
2. The member’s physical or mental impairment is such that self-execution of required nursing care is improbable or impossible.

“Physical disability” means a severe, chronic condition that is attributable to a physical impairment that results in substantial limitations of physical functioning in three or more of the following areas of major life activities: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, and economic self-sufficiency.

“Service plan” means a person-centered, outcome-based plan of services that is written by the member’s case manager with input and direction from the member and that addresses all relevant services and supports being provided. The service plan is developed by the interdisciplinary team, which includes the member and, if appropriate, the member’s legal representative, member’s family, service providers, and others directly involved with the member.

“Skilled nursing facility level of care” means that the following conditions are met:

1. The member’s medical condition requires skilled nursing services or skilled rehabilitation services as defined in 42 CFR 409.31(a), 409.32, and 409.34 as amended to July 1, 2026.
2. Services are provided in accordance with the general provisions for all Medicaid providers and services as described in rule 441—79.10(249A).
3. Documentation submitted for review indicates that the member has:
 - A physician order for all skilled services.
 - Services that require the skills of medical personnel, including registered nurses, licensed practical nurses, physical therapists, occupational therapists, speech pathologists, or audiologists.
 - An individualized care plan that identifies support needs.
 - Confirmation that skilled services are provided to the member.
 - Skilled services that are provided by, or under the supervision of, medical personnel as described above.
 - Skilled nursing services that are needed and provided seven days a week or skilled rehabilitation services that are needed and provided at least five days a week.

“Third-party payment” means payment from an individual, institution, corporation, or public or private provider that is liable to pay part or all of the medical costs incurred as a result of injury or disease on behalf of a member of medical assistance.

“*Waiver year*” means a 12-month period commencing on April 1 of each year.

[ARC 0318D, IAB 5/27/26, effective 7/1/26]

441—83.102(249A) Eligibility. To be eligible for physical disability waiver services, a member must meet eligibility criteria set forth in subrule 83.102(1) and be determined to need a service allowable under the program per subrule 83.102(2).

83.102(1) Eligibility criteria. All of the following criteria must be met. The person must:

- a. Have a physical disability.
- b. Be blind or disabled as determined by the receipt of social security disability benefits or by a disability determination made through the department. Disability determinations are made according to supplemental security income guidelines under Title XVI of the Social Security Act as amended to July 1, 2026, or the disability guidelines for the Medicaid employed people with disabilities coverage group.
- c. Be ineligible for the HCBS intellectual disability waiver.
- d. Have the ability to hire, supervise, and fire the provider as determined by the service worker, and be willing to do so, or have a parent or guardian named by probate court, or attorney in fact under a durable power of attorney for health care who will take this responsibility on behalf of the member.
- e. Be eligible for Medicaid under 441—Chapter 75.
- f. Be aged 18 years to 64 years.
- g. Reserved.
- h. Be in need of skilled nursing or intermediate care facility level of care based on information submitted on a completed interRAI - Pediatric Home Care (PEDS-HC) for those aged 18 to 20 or the interRAI - Home Care (HC) for those aged 21 and over and other supporting documentation as relevant. The interRAI - PEDS-HC and the interRAI - HC are available on request from the department. Copies of the completed information submission tool for an individual are available to that individual from the individual’s case manager or MCO.

(1) Initial decisions on level of care will be made for the department by the department within two working days of receipt of medical information. Iowa Medicaid determines whether the level of care requirement is met based on medical necessity and the appropriateness of the level of care under 441—subrules 79.10(1) and 79.10(2).

(2) Adverse decisions may be appealed to the department pursuant to 441—Chapter 2506.

- i. Choose HCBS.
- j. Use a minimum of one unit of service per calendar quarter under this program.
- k. For the consumer choices option as set forth in 441—subrule 78.46(6), not be living in a residential care facility.

83.102(2) Need for services.

a. The applicant will have a service plan that is developed by the applicant and a department service worker. The plan must be completed and approved before service provision.

(1) The designated case manager will identify the need for service based on the needs of the applicant, as documented in the information submission tool listed in paragraph 83.102(1) “h,” as well as the availability and appropriateness of services.

(2) The service worker will have a face-to-face visit with the member at least annually.

b. The total cost of physical disability waiver services, excluding the cost of home and vehicle modifications, will not exceed \$793.20 per month.

83.102(3) Slots. The total number of persons receiving HCBS physical disability waiver services in the state will be limited to the number provided in the waiver approved by the Secretary of the U.S. Department of Health and Human Services. These slots will be available on a first-come, first-served basis.

83.102(4) Securing a slot.

a. The department field office will enter all waiver applications into the institutional and waiver authorization and narrative system (IoWANS) to determine whether a slot is available for all new applicants for the HCBS physical disability waiver program.

(1) For applicants not currently receiving Medicaid, the department field office will make the entry by the end of the fifth working day after receipt of a completed application for health services and help paying costs or within five working days after receipt of disability determination, whichever is later.

(2) For current Medicaid members, the department field office will make the entry by the end of the fifth working day after receipt of a written request signed and dated by the waiver applicant.

b. If no slot is available, the department will enter applicants on the HCBS physical disabilities waiver waiting list according to the following:

(1) Applicants not currently eligible for Medicaid will be entered on the basis of the date a completed health services application is received by the department or upon receipt of disability determination, whichever is later. Applicants currently eligible for Medicaid will be added on the basis of the date the applicant requests HCBS physical disability program services. In the event that more than one application is received on the same day, applicants will be entered on the waiting list on the basis of the day of the month of their birthday, the lowest number being first on the list. Any subsequent tie will be decided by the month of birth, January being month one and the lowest number.

(2) Persons who do not fall within the available slots will have their applications rejected but their names will be maintained on the waiting list. As slots become available, persons will be selected from the waiting list to maintain the number of approved persons on the program based on their order on the waiting list.

83.102(5) *HCBS physical disability waiver waiting list.* When services are denied because the limit on the number of slots is reached, a notice of decision denying service based on the limit and stating that the person's name will be put on a waiting list will be sent to the person by the department. [ARC 0318D, IAB 5/27/26, effective 7/1/26]

441—83.103(249A) Application.

83.103(1) *Application for financial eligibility.* The application process as specified in rules 441—76.1(249A) through 441—76.6(249A) will be followed.

83.103(2) *Approval of application for eligibility.*

a. Applications for this waiver will be initiated on behalf of the applicant who is a resident of a medical institution with the applicant's consent or with the consent of the applicant's legal representative by the discharge planner of the medical facility where the applicant resides at the time of application.

(1) The discharge planner will contact the member's MCO or designated case manager to arrange for completion of the appropriate information submission tool as listed in paragraph 83.102(1) "h."

(2) After completing the determination of the level of care needed by the applicant, the department will inform the income maintenance worker and the discharge planner of the decision.

b. Applications for this waiver will be initiated by the applicant, the applicant's parent or legal guardian, or the applicant's attorney in fact under a durable power of attorney for health care on behalf of the applicant who is residing in the community.

(1) The applicant's MCO or the designated case manager will arrange for the completion of the appropriate information submission tool as listed in paragraph 83.102(1) "h" and submit it to the department.

(2) After completing the determination of the level of care needed by the applicant, the department will inform the income maintenance worker and the applicant, the applicant's parent or legal guardian, or the applicant's attorney in fact under a durable power of attorney for health care.

c. Eligibility for this waiver will be effective as of the date when both the eligibility criteria in subrule 83.102(1) and need for services in subrule 83.102(2) have been established. Decisions will be mailed or given to the applicant, the applicant's parent or legal guardian, or the applicant's attorney in

fact under a durable power of attorney for health care on the date when each eligibility determination is completed.

d. An applicant will be given the choice between waiver services and institutional care. The applicant or the applicant's parent, legal guardian, or attorney in fact under a durable power of attorney for health care will sign the information submission tool, indicating that the applicant has elected home- and community-based services.

e. The applicant, the applicant's parent or guardian, or the applicant's attorney in fact under a durable power of attorney for health care will cooperate with the designated case manager in the development of the service plan prior to the start of services.

f. HCBS physical disability waiver services provided prior to both approvals of eligibility for the waiver cannot be paid.

g. HCBS physical disability waiver services are not available in conjunction with other HCBS waiver programs. The member may also receive in-home health-related care service if eligible for that program.

83.103(3) *Effective date of eligibility.*

a. The effective date of eligibility for the waiver for persons who are already determined eligible for Medicaid is the date on which the person is determined to meet all of the criteria set forth in subrule 83.102(1).

b. The effective date of eligibility for the waiver for persons who qualify for Medicaid due to eligibility for the waiver services is the date on which the person is determined to meet all of the criteria set forth in subrule 83.102(1) and when the eligibility factors set forth in 441—paragraph 75.6(4) “*b*” and, for married persons, in rule 441—75.82(249A) have been satisfied.

c. Eligibility for the waiver continues until the member fails to meet eligibility criteria listed in subrule 83.102(1). Members who return to inpatient status in a medical institution for more than 120 consecutive days will be reviewed by Iowa Medicaid to determine additional inpatient needs for possible termination from the physical disability waiver. The member will be reviewed for eligibility under other Medicaid coverage groups in accordance with rule 441—76.17(249A). The member will be notified of that decision through a notice of decision.

If the member returns home before the effective date of the notice of decision and the member's condition has not substantially changed, the denial may be rescinded and eligibility may continue.

83.103(4) *Attribution of resources.* For the purposes of attributing resources as provided in rule 441—75.82(249A), the date on which the waiver member meets the institutional level of care requirement as determined by the department or an appeal decision will be used as the date of entry to the medical institution. Only one attribution of resources will be completed per person. Attributions completed for a prior institutionalization will be applied to the waiver application.

[ARC 0318D, IAB 5/27/26, effective 7/1/26]

441—83.104(249A) Client participation. Members who are financially eligible under 441—paragraph 75.6(4) “*b*” (the 300 percent group) must contribute a client participation amount to the cost of physical disability waiver services.

83.104(1) *Computation of client participation.* Client participation will be computed by deducting a maintenance needs allowance equal to 300 percent of the maximum supplemental security income (SSI) grant for an individual from the member's total income. For a couple, client participation is determined as if each person were an individual.

83.104(2) *Limitation on payment.* If the sum of the third-party payment and client participation equals or exceeds the reimbursement for the specific physical disability waiver service, Medicaid will make no payments for the waiver service. However, Medicaid will make payments to other medical providers.

[ARC 0318D, IAB 5/27/26, effective 7/1/26]

441—83.105(249A) Redetermination. A complete financial redetermination of eligibility for the physical disability waiver will be completed at least once every 12 months. A redetermination

of continuing eligibility factors will be made when a change in circumstances occurs that affects eligibility in accordance with rule 441—83.102(249A). A redetermination will contain the components listed in rule 441—83.102(249A).

[ARC 0318D, IAB 5/27/26, effective 7/1/26]

441—83.106(249A) Allowable services. The services allowable under the physical disability waiver are member-directed attendant care, home and vehicle modification, personal emergency response system, transportation, specialized medical equipment, financial management, independent support brokerage, self-directed personal care, self-directed community supports and employment, and individual-directed goods and services as set forth in rule 441—78.46(249A).

[ARC 0318D, IAB 5/27/26, effective 7/1/26]

441—83.107(249A) Individual service plan. An individualized service plan will be prepared and used for each HCBS physical disability waiver member. The service plan will be developed and approved by the member, the member's interdisciplinary team and the designated case manager prior to services beginning and payment being made to the provider.

83.107(1) Information in plan. The plan will be in accordance with 441—subrule 24.4(3) and will additionally include the following information to assist in evaluating the program:

- a. A listing of all services received by a member at the time of waiver program enrollment.
- b. The name of all providers responsible for providing all services.
- c. All service funding sources.
- d. The amount of the service to be received by the member.
- e. Whether the member has elected the member choices option and, if so:
 - (1) The independent support broker selected by the member; and
 - (2) The financial management service selected by the member.
- f. A plan for emergencies and identification of the supports available to the member in an emergency.

83.107(2) Annual assessment. The department or an MCO will review the member's need for continued care annually and recertify the member's need for long-term care services, pursuant to paragraph 83.102(1) "h" and the appeal process in rule 441—83.109(249A), based on the appropriate information submission tool as listed in paragraph 83.102(1) "h" and other supporting documentation as relevant.

a. The department or the member's MCO will be responsible for annual redetermination of the level of care.

b. The MCO must submit documentation to Iowa Medicaid for all reassessments, performed at least annually, that indicate a change in the member's level of care. The department will make a final determination for any reassessments that indicate a change in the level of care. If the level of care reassessment indicates no change in level of care, the member is approved to continue at the already established level of care.

[ARC 0318D, IAB 5/27/26, effective 7/1/26]

441—83.108(249A) Adverse service actions.

83.108(1) Denial. An application for services will be denied when it is determined by the department that:

a. All of the medically necessary service needs cannot be met in a home- or community-based setting.

b. Service needs exceed the reimbursement maximums.

c. Service needs are not met by the services provided.

d. Needed services are not available or received from qualifying providers.

e. The physical disability waiver service is not identified in the member's service plan.

f. There is another community resource available to provide the service or a similar service free of charge to the member that will meet the member's needs.

- g. The member receives services from other Medicaid waiver providers.
- h. The member or legal representative requests termination from the services.

83.108(2) Reduction. A particular service may be reduced when the department determines that the provisions of 441—paragraph 130.5(3) “a” or “b” apply.

83.108(3) Termination. A particular service may be terminated when the department determines that:

- a. The provisions of 441—paragraph 130.5(2) “d,” “g,” or “h” apply.
- b. Needed services are not available or received from qualifying providers.
- c. The physical disability waiver service is not identified in the member’s annual service plan.
- d. Service needs are not met by the services provided.
- e. Services needed exceed the service unit or reimbursement maximums.
- f. Completion or receipt of required documents by the member for the physical disability waiver service has not occurred.
- g. The member receives services from other Medicaid providers.
- h. The member or legal representative requests termination from the services.

[ARC 0318D, IAB 5/27/26, effective 7/1/26]

441—83.109(249A) Appeal rights. Notice of adverse action will be given in accordance with rule 441—16.2(17A). The right to appeal will be given in accordance with 441—Chapter 2506.

[ARC 0318D, IAB 5/27/26, effective 7/1/26]

441—83.110 to 83.120 Reserved.

These rules are intended to implement Iowa Code sections 249A.3 and 249A.4.

DIVISION VII—HCBS CHILDREN’S MENTAL HEALTH WAIVER SERVICES

441—83.121(249A) Definitions.

“*Assessment*” means the review of the member’s current functioning in regard to the member’s situation, needs, abilities, desires, and goals.

“*Case manager*” means the person designated to provide Medicaid targeted case management services for the member.

“*CMS*” means the Centers for Medicare and Medicaid Services, a division of the U.S. Department of Health and Human Services.

“*Deeming*” means considering parental or spousal income or resources as income or resources of a member in determining eligibility for a member according to Supplemental Security Income program guidelines.

“*DSM-5*” means the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, published by the American Psychiatric Association as amended to July 1, 2026.

“*Guardian*” means a parent of a member or a legal guardian appointed by the court.

“*HCBS*” means home- and community-based services provided under a Medicaid waiver.

“*IME QIO*” means the entity contracted with the department that determines the level of care for members initially applying for or continuing to receive children’s mental health waiver services.

“*Interdisciplinary team*” means the member, the member’s family, and persons of varied professional and nonprofessional backgrounds with knowledge of the member’s needs, as designated by the member and the member’s family, who meet to develop a service plan based on the individualized needs of the member.

“*Managed care*” means a system that provides the coordinated delivery of services and supports that are necessary and appropriate, delivered in the least restrictive settings and in the least intrusive manner. Managed care seeks to balance three factors:

1. Achieving high-quality outcomes for participants.
2. Coordinating access.
3. Containing costs.

“Managed care organization” or *“MCO”* means an entity that (1) is under contract with the department to provide services to Medicaid recipients and (2) meets the definition of “health maintenance organization” as defined in Iowa Code section 514B.1.

“Medical institution” means a nursing facility, an intermediate care facility for persons with an intellectual disability, a psychiatric hospital or psychiatric medical institution for children, or a state mental health institute that has been approved as a Medicaid vendor.

“Member” means an individual up to the age of 18 who is included in a Medicaid coverage group listed in rule 441—75.1(249A) and is a recipient of children’s mental health waiver services.

“Mental health professional” means a person who meets all of the following conditions:

1. Holds at least a master’s degree in a mental health field, including but not limited to psychology, counseling and guidance, psychiatric nursing and social work; or is a doctor of medicine or osteopathic medicine; and

2. Holds a current Iowa license when required by the Iowa professional licensure laws (such as a psychiatrist, a psychologist, a marital and family therapist, a mental health counselor, an advanced registered nurse practitioner, a psychiatric nurse, or a social worker); and

3. Has at least two years of postdegree experience supervised by a mental health professional in assessing mental health problems, mental illness, and service needs and in providing mental health services.

“Psychiatric medical institution for children level of care” means that the member has been diagnosed with a serious emotional disturbance and an independent team as identified in 441—subrule 85.10(3) has certified that ambulatory care resources available in the community do not meet the treatment needs of the recipient, that proper treatment of the recipient’s psychiatric condition requires services on an inpatient basis under the direction of a physician, and that the services can reasonably be expected to improve the recipient’s condition or prevent further regression so that the services will no longer be needed.

“Serious emotional disturbance” means a diagnosable mental, behavioral, or emotional disorder that (1) is of sufficient duration to meet diagnostic criteria for the disorder specified by DSM-5 and (2) has resulted in a functional impairment that substantially interferes with or limits a member’s role or functioning in family, school, or community activities. “Serious emotional disturbance” does not include neurodevelopmental disorders, substance-related disorders, or conditions or problems classified in DSM-5 as “other conditions that may be a focus of clinical attention” unless these conditions co-occur with another diagnosable serious emotional disturbance.

“Service plan” means a person-centered, outcome-based plan of services that is written by the member’s case manager with input and direction from the member and that addresses all relevant services and supports being provided. The service plan is developed by the interdisciplinary team that includes the member and, if appropriate, the member’s legal representative, member’s family, service providers, and others directly involved with the member.

“Targeted case management” means Medicaid case management services accredited under 441—Chapter 24 and provided according to 441—Chapter 90 for members eligible for the children’s mental health waiver.

“Waiver year” for the children’s mental health waiver means a 12-month period commencing on July 1 of each year.

[ARC 0318D, IAB 5/27/26, effective 7/1/26]

441—83.122(249A) Eligibility. To be eligible for children’s mental health waiver services, a member must meet all of the following requirements:

83.122(1) Age. The member must be under 18 years of age.

83.122(2) Diagnosis. The member must be diagnosed with a serious emotional disturbance.

a. Initial certification. For initial application to the HCBS children’s mental health waiver program, psychological documentation that substantiates a mental health diagnosis of serious

emotional disturbance as determined by a mental health professional must be current within the 12-month period before the application date.

b. Ongoing certification. A mental health professional must complete an annual evaluation that substantiates a mental health diagnosis of serious emotional disturbance.

83.122(3) Level of care. The applicant must be certified as being in need of a level of care that, but for the waiver, would be provided in a psychiatric hospital serving children under the age of 21. The department or an MCO will certify the applicant's level of care annually based on information submitted on the interRAI Early Years for children aged 3 and under or on the interRAI - child and youth mental health (ChYMH) for those aged 4 to 20 and other supporting documentation as relevant. For those aged 12 to 18, the interRAI - adolescent supplement will also be completed in addition to the interRAI - ChYMH. The interRAI Early Years, interRAI - ChYMH and interRAI - adolescent supplement are available on request from the department. Copies of the completed information submission tool for an individual are available to that individual from the individual's case manager or MCO.

83.122(4) Financial eligibility. The member must be eligible for Medicaid as follows:

- a.* Be eligible for Medicaid under a supplemental security income (SSI), SSI-related, FMAP, or FMAP-related coverage group; or
- b.* Be eligible under the special income level (300 percent) coverage group; or
- c.* Become eligible through application of the institutional deeming rules; or
- d.* Would be eligible for Medicaid if in a medical institution. For this purpose, deeming of parental or spousal income or resources ceases in the month after the month of application.

83.122(5) Choice of program. The applicant must choose HCBS children's mental health waiver services over institutional care, as indicated by the signature of the applicant's parent or legal guardian on the assessment.

83.122(6) Need for service. The member must have service needs that can be met under the children's mental health waiver program, as documented in the service plan developed in accordance with rule 441—83.127(249A).

- a.* The member must be a recipient of case management or be identified to receive case management immediately following program enrollment.
- b.* The total cost of children's mental health waiver services needed to meet the member's needs, excluding the cost of environmental modifications, adaptive devices and therapeutic resources, cannot exceed \$2,274.96 per month.
- c.* At a minimum, each member must receive one billable unit of a children's mental health waiver service per calendar quarter.
- d.* A member may not receive children's mental health waiver services and foster family care services under 441—Chapter 202 at the same time.
- e.* A member may be enrolled in only one HCBS waiver program at a time.

[ARC 0318D, IAB 5/27/26, effective 7/1/26]

441—83.123(249A) Application. The Medicaid application process as specified in rules 441—76.1(249A) through 441—76.6(249A) will be followed for an application for HCBS children's mental health waiver services.

83.123(1) Program limit. The number of persons who may be approved for the HCBS children's mental health waiver shall be subject to the number of members to be served as set forth in the federally approved HCBS children's mental health waiver. When the number of applicants exceeds the number of members specified in the approved waiver, the member's application will be rejected and the member's name shall be placed on a waiting list.

a. The local office will determine whether a payment slot is available by the end of the fifth working day after receipt of:

- (1) A completed application for health services or help paying costs from a member who is not currently a Medicaid member; or

- (2) A written request signed and dated by a Medicaid member's parent or legal guardian.
- b. When a payment slot is available, the local office will enter the application into institutional and waiver authorization and narrative system (IoWANS) to begin the waiver approval process.
 - (1) The department will hold the payment slot for the member as long as reasonable efforts are being made to arrange services and the member has not been determined to be ineligible for the program.
 - (2) If services have not been initiated and reasonable efforts are no longer being made to arrange services, the slot will revert for use by the next member on the waiting list, if applicable. The member must reapply for a new slot.
- c. If no payment slot is available, the department will enter the names of persons on a waiting list according to the following:
 - (1) The names of applicants not currently eligible for Medicaid shall be entered on the waiting list on the basis of the date a completed application for health services or help paying costs is received by the department;
 - (2) The names of Medicaid members will be added to the waiting list on the date as specified in paragraph 83.123(1) "a."
 - (3) In the event that more than one application is received at one time, the names of members will be entered on the waiting list on the basis of the month of birth, January being month one and the lowest number.
- d. Members whose names are on the waiting list will be contacted to reapply as slots become available, based on the order of the waiting list, so that the number of approved members on the program is maintained.
 - (1) Once a payment slot is assigned, the department will give written notice to the member within five working days.
 - (2) The department will hold the payment slot for 30 days for the member to file a new application.
 - (3) If an application has not been filed within 30 days, the slot will revert for use by the next member on the waiting list, if applicable. The member originally assigned the slot must reapply for a new slot.
- e. The state reserves payment slots each waiver year (October 1 to September 30) for use by members living in a state of Iowa mental health institute (MHI), a psychiatric residential treatment facility (PRTF), or an out-of-state facility placement who choose to access services in the children's mental health waiver program and leave the MHI, PRTF, or out-of-state placement to live within their family home. For the purpose of reserved capacity within the children's mental health waiver program, an MHI is defined in Iowa Code section 226.1 and a PRTF is defined in 42 CFR 483.352 as amended to July 1, 2026.
 - (1) Applicants who currently reside in an MHI, PRTF, or out-of-state placement and have resided in that setting for four or more months may request a reserved capacity slot through the children's mental health waiver program.
 - (2) Applicants will be allocated a reserved capacity slot on the basis of the date the request is received by the income maintenance worker or the waiver slot manager.
 - (3) In the event that more than one request for a reserved capacity slot is received at one time, applicants will be allocated the next available reserved capacity slot on the basis of the month of birth, January being month one and the lowest number.
 - (4) Persons who do not fall within the available reserved capacity slots will have their names maintained on the reserved capacity slot waiting list. As reserved capacity slots become available at the beginning of the next waiver year, persons will be selected from the reserved capacity slot waiting list to utilize the number of approved reserved capacity slots based on their order on the waiting list.

83.123(2) *Approval of waiver eligibility.*

- a. *Time limit.* Applications for the HCBS children's mental health waiver program will be processed within 30 days unless one or more of the following conditions exist:

(1) An application has been filed and is pending for federal SSI benefits.

(2) The application is pending because the department has not received information for a reason that is beyond the control of the member or the department.

(3) The application is pending because the assessment has not been completed. When a determination is not completed 90 days after the date of application due to the lack of a completed assessment, the application will be denied.

b. Notice of decisions. The department will mail or give decisions to the applicant on the dates when eligibility and level of care determinations are completed.

83.123(3) *Effective date of eligibility.* The effective date of a member's eligibility for children's mental health waiver services will be the first date that all of the following conditions exist:

- a.* All eligibility requirements are met; and
- b.* Eligibility and level of care determinations have been made.

[ARC 0318D, IAB 5/27/26, effective 7/1/26]

441—83.124(249A) Financial participation. A member must contribute to the cost of children's mental health waiver services to the extent of the member's total income less 300 percent of the maximum monthly payment for one person under the federal SSI program.

[ARC 0318D, IAB 5/27/26, effective 7/1/26]

441—83.125(249A) Redetermination. The department will redetermine a member's eligibility for the children's mental health waiver at least once every 12 months or when there is significant change in the member's situation or condition.

83.125(1) *Eligibility review.*

a. Every 12 months, the department will review a member's eligibility in accordance with procedures in rule 441—76.17(249A). The review will verify continuing eligibility factors as specified in rule 441—83.122(249A).

b. The department or an MCO will review the member's need for continued care annually and recertify the member's need for long-term care services, pursuant to rule 441—83.122(249A) and the appeal process in rule 441—83.129(249A), based on the completed information submission tool designated in subrule 83.122(3) and other supporting documentation as relevant.

c. The department or the member's MCO will be responsible for annual redetermination of the level of care.

d. The MCO must submit documentation to Iowa Medicaid for all reassessments, performed at least annually, that indicate a change in the member's level of care. The department will make a final determination for any reassessments that indicate a change in the level of care. If the level of care reassessment indicates no change in level of care, the member is approved to continue at the already established level of care.

83.125(2) *Continuation of eligibility.* A member's waiver eligibility will continue until one of the following conditions occurs.

a. The member fails to meet eligibility criteria listed in rule 441—83.122(249A).

b. The member is an inpatient of a medical institution for 120 or more consecutive days.

(1) After the member has spent 120 consecutive days in a medical institution, the local office will terminate the member's waiver eligibility and review the member for eligibility under other Medicaid coverage groups. The local office will notify the member and the member's parents or legal guardian through a notice of decision.

(2) If the member returns home after 120 consecutive days, the member must reapply for children's mental health waiver services, and Iowa Medicaid must redetermine the member's level of care.

c. The member does not reside at the member's natural home for a period of 60 consecutive days. After the member has resided outside the home for 60 consecutive days, the local office will terminate the member's waiver eligibility and review the member for eligibility under other Medicaid

coverage groups. The local office will notify the member and the member's parents or legal guardian through a notice of decision.

83.125(3) *Payment slot.* When a member loses waiver eligibility, the member's assigned payment slot will revert for use to the next member on the waiting list.

[ARC 0318D, IAB 5/27/26, effective 7/1/26]

441—83.126(249A) Allowable services. Services allowable under the children's mental health waiver will be provided as set forth in rule 441—78.52(249A) and will include:

1. Environmental modifications, adaptive devices and therapeutic resources;
2. Family and community support services;
3. In-home family therapy; and
4. Respite care.

[ARC 0318D, IAB 5/27/26, effective 7/1/26]

441—83.127(249A) Service plan. The member's case manager will prepare an individualized service plan for each member that meets the requirements set for case plans in rule 441—130.7(234).

83.127(1) The service plan will be developed through an interdisciplinary team process.

83.127(2) The service plan will be developed annually or when there is significant change in the member's situation or condition.

83.127(3) The service plan will be based on information in the completed information submission tool designated in subrule 83.122(3) and other supporting documentation as relevant.

83.127(4) The service plan will specify the type and frequency of the waiver services and the providers that will deliver the services.

83.127(5) The service plan will identify and justify any restriction of the member's rights.

[ARC 0318D, IAB 5/27/26, effective 7/1/26]

441—83.128(249A) Adverse service actions.

83.128(1) *Denial.* An application for children's mental health waiver services will be denied when the department determines that:

- a. The member is not eligible for or in need of waiver services.
- b. Needed services are not available or received from qualified providers.
- c. Service needs exceed the limit on aggregate monthly costs established in paragraph 83.122(6) "b" or are not met by the services provided.

83.128(2) *Termination.* A member's participation in the children's mental health waiver program may be terminated when the department determines that:

- a. The provisions of 441—paragraph 130.5(2) "a," "b," "c," "g," or "h" apply.
- b. The costs of the children's mental health waiver services for the member exceed the aggregate monthly costs established in paragraph 83.122(6) "b."
- c. The member receives care in a hospital, nursing facility, psychiatric hospital serving children under the age of 21, or psychiatric medical institution for children for 120 days in any one stay.
- d. The physical or mental condition of the member requires more care than can be provided in the member's own home, as determined by the member's case manager.
- e. Service providers are not available.

83.128(3) *Reduction.* Reduction of services will apply as specified in 441—paragraphs 130.5(3) "a" and "b."

[ARC 0318D, IAB 5/27/26, effective 7/1/26]

441—83.129(249A) Appeal rights. Notice of adverse action will be given in accordance with rule 441—16.2(17A). The right to appeal will be given in accordance with 441—Chapter 2506.

[ARC 0318D, IAB 5/27/26, effective 7/1/26]

These rules are intended to implement Iowa Code section 249A.4.

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CHAPTER 90
FEE-FOR-SERVICE CASE MANAGEMENT

Chapter rescission date pursuant to Iowa Code section 17A.7: 7/1/31

441—90.1(249A) Definitions.

“*Adult*” means a person 18 years of age or older on the first day of the month in which service begins.

“*Applicant*” means a person who has applied for an HCBS waiver or habilitation program.

“*Case management*” means the categories of case management: targeted case management (TCM) and case management provided to members enrolled in a 1915(c) waiver.

“*Case manager*” means the staff person providing the case management services regardless of the entity providing the service.

“*Child*” means a person other than an adult.

“*Chronic mental illness*” means a condition present in adults who have a persistent mental or emotional disorder that seriously impairs their functioning relative to such primary aspects of daily living as personal relations, living arrangements, or employment. The definition of chronic mental illness and qualifying criteria are found in 441—Chapter 24. For purposes of this chapter, people with mental disorders resulting from Alzheimer’s disease or substance abuse shall not be considered chronically mentally ill.

“*Core standardized assessment*” or “*CSA*” means an assessment instrument for determining the suitability of non-institutionally based long-term services and supports for an individual. The instrument shall be used in a uniform manner throughout the state to determine an applicant’s or member’s needs for training, support services, medical care, transportation, and other services and to develop an individual service plan to address such needs.

“*Developmental disability*” means a severe, chronic disability that is determined through professionally administered screening and evaluations.

“*Fee-for-service member*” or “*FFS member*” means a member who is not enrolled with a managed care organization.

“*Home- and community-based services*” or “*HCBS*” means services provided pursuant to Sections 1915(c) and 1915(i) of the Social Security Act as amended to July 1, 2026.

“*Intellectual disability*” means a diagnosis of intellectual disability (intellectual developmental disorder), global developmental delay, or unspecified intellectual disability (intellectual developmental disorder). Diagnosis criteria are outlined in 441—Chapter 83.

“*Major incident*” means an occurrence that involves a member who is enrolled in an HCBS waiver, TCM, or habilitation services and that:

1. Results in a physical injury to or by the member that requires a physician’s treatment or admission to a hospital;
2. Results in the death of any person;
3. Requires emergency mental health treatment for the member;
4. Requires the intervention of law enforcement;
5. Requires a report of child abuse pursuant to Iowa Code section 232.69, a report of dependent adult abuse pursuant to Iowa Code section 235B.3, or a report of elder abuse pursuant to Iowa Code chapter 235F;
6. Constitutes a prescription medication error or a pattern of medication errors that leads to the outcome in numbered paragraph “1,” “2,” or “3”; or
7. Involves a member’s location being unknown by provider staff who are responsible for protective oversight.

“*Managed care organization*” or “*MCO*” means the same as defined in 441—Chapter 73.

“Medical institution” means an institution that is organized, staffed, and authorized to provide medical care as set forth in the most recent amendment to 42 CFR Section 435.1009 as amended to October 20, 2022.

“Member” means a person who has been determined to be eligible for Medicaid under 441—Chapter 75.

“Minor incident” means an occurrence that involves a member who is enrolled in an HCBS waiver, TCM, or habilitation services and that is not a major incident but that:

1. Results in the application of basic first aid;
2. Results in bruising;
3. Results in seizure activity;
4. Results in injury to self, to others, or to property; or
5. Constitutes a prescription medication error.

“Person-centered service plan” or *“service plan”* means a service plan created through the person-centered planning process, directed by the member with long-term care needs or the member’s guardian or representative, to identify the member’s strengths, capabilities, preferences, needs, and desired outcomes.

“Rights restriction” means limitations not imposed on the general public in the areas of communication, mobility, finances, medical or mental health treatment, intimacy, privacy, type of work, religion, place of residence, and people with whom a member may share a residence.

“Targeted case management” or *“TCM”* means case management services furnished to assist members who are part of a targeted population.

“Targeted population” means people who meet one of the following criteria:

1. An adult who is identified with a primary diagnosis of intellectual disability, chronic mental illness, or developmental disability; or
2. A child who is eligible to receive HCBS waiver services according to 441—Chapter 83.

A member enrolled with an MCO is not part of the targeted population.

[ARC 0319D, IAB 5/27/26, effective 7/1/26]

441—90.2(249A) Targeted case management. This rule applies only to the case management category of TCM and the defined targeted population.

90.2(1) Eligibility for targeted case management. A person who meets all of the following criteria will be eligible for TCM:

- a.* The person is eligible for Medicaid or is conditionally eligible under 441—Chapter 75;
- b.* The person is a member of a targeted population;
- c.* The person resides in a community setting or qualifies for transitional case management as set forth in subrule 90.2(4);
- d.* The person has applied for TCM in accordance with the policies of the provider;
- e.* The person is not eligible for or enrolled in an MCO.

90.2(2) Determination of need for targeted case management. Assessment at least every 365 days since the date of identified need for TCM is required as a condition of eligibility under the medical assistance program. The TCM provider manual found on the department’s website and as amended to July 1, 2026, contains more information.

90.2(3) Application for targeted case management. The TCM provider shall process a received application for TCM no later than 30 days after receipt of the application. The Medicaid manual for TCM found on the department’s website and as amended to July 1, 2026, has more information.

a. Application decision for targeted case management. The TCM provider shall inform the applicant, or the applicant’s guardian or representative, of any decision to approve, deny, or delay the service in accordance with the notification requirements in 441—Chapter 16.

b. Denial of applications. The TCM provider will deny an application for service when:

- (1) The applicant is not currently eligible for Medicaid;
- (2) The applicant does not meet the eligibility criteria in 441—subrule 90.2(1);

- (3) The applicant, or the applicant's guardian or representative, withdraws the application;
- (4) The applicant does not provide information required to process the application;
- (5) The applicant is receiving duplicative TCM from another Medicaid provider; or
- (6) The applicant does not have a need for TCM.

90.2(4) *Transition to a community setting.* The Medicaid manual for TCM found on the department's website and as amended to July 1, 2026, contains information about services that may be provided to a member transitioning to a community setting.

[ARC 0319D, IAB 5/27/26, effective 7/1/26]

441—90.3(249A) Termination of TCM services.

90.3(1) TCM shall be terminated only when:

- a. The member does not meet eligibility criteria under rule 441—90.2(249A);
- b. The member has achieved all goals and objectives of the service;
- c. The member has no ongoing need for TCM;
- d. The member is receiving TCM based on eligibility under an HCBS program but is no longer eligible for the program;
- e. The member or the member's guardian or representative requests termination;
- f. The member is unwilling or unable to accept further services; or
- g. The member or the member's guardian or representative fails to provide access to information necessary for the development of the service plan or for implementation of TCM.

90.3(2) The provider shall notify the member or the member's guardian or representative in writing of the termination of TCM, in accordance with 441—Chapter 16.

[ARC 0319D, IAB 5/27/26, effective 7/1/26]

441—90.4(249A) Case management services. This rule applies to all categories of case management and all populations covered by case management.

90.4(1) *Covered services.* The following shall be included in FFS case management services provided to members.

a. *Assessment.* Initial assessments and regular reassessments must be completed for each member to determine the need for medical, social, educational, housing, transportation, vocational, or other services, as specified in the Medicaid manual for TCM found on the department's website and as amended through July 1, 2026.

b. *Person-centered service plan.* The case manager shall develop and revise a comprehensive, person-centered service plan at least every 365 days in accordance with the Medicaid manual for TCM found on the department's website and as amended to July 1, 2026.

c. *Monitoring and follow-up.* The case manager shall perform monitoring activities and make contacts that are necessary to ensure the health, safety, and welfare of the member and to ensure that the person-centered service plan is effectively implemented and adequately addresses the needs of the member.

d. *Contacts.* The case manager shall have at least one face-to-face contact with the member in the member's residence at least quarterly. The case manager shall have at least one contact per month with the member or the member's guardians or representatives. This contact may be face-to-face or by telephone.

90.4(2) *Exclusions.* Payment will not be made for activities otherwise within the definition of case management services when any of the following conditions exist:

- a. The activities are an integral component of another covered Medicaid service.
- b. The activities constitute the direct delivery of underlying medical, social, educational, housing, transportation, vocational or other services to which a member has been referred.
- c. The activities are components of the administration of foster care programs.
- d. The activities for which a member may be eligible are a component of the administration of another nonmedical program, such as a guardianship, child welfare or child protective services, parole, probation, or special education program, except for case management that is included in

an individualized education program or individualized family service plan consistent with Section 1903(c) of the Social Security Act as amended to August 1, 2025.

e. The activities duplicate institutional discharge planning.

[ARC 0319D, IAB 5/27/26, effective 7/1/26]

441—90.5(249A) Rights restrictions. This rule applies to all categories of case management and all populations covered by case management. Any effort to restrict the rights of a member, or the member's preferences or goals must be justified by a specific individualized assessed safety need and documented in the person-centered service plan. For more information, refer to the Person Centered Service Plan manual as amended to July 1, 2026, available on the department's website.

[ARC 0319D, IAB 5/27/26, effective 7/1/26]

441—90.6(249A) Documentation and billing. This rule applies to all categories of case management and all populations covered by case management. The case management billing manual for case management contact documentation and billing requirements available on the department's website and as amended to July 1, 2026, contains more information.

[ARC 0319D, IAB 5/27/26, effective 7/1/26]

441—90.7(249A) Case management services provider requirements.

90.7(1) This rule applies to all categories of case management and all populations covered by case management. Major or minor incidents shall be reported according to the case management incident reporting manual available on the department's website and as amended to July 1, 2026.

90.7(2) Quality assurance. Case management services providers shall cooperate with quality assurance activities conducted by Iowa Medicaid, as well as any other state or federal entity with oversight authority to ensure the health, safety, and welfare of Medicaid members. These activities may include but are not limited to:

- a.* Postpayment review of case management services;
- b.* Review of incident reports;
- c.* Review of reports of abuse or neglect; and
- d.* Technical assistance in determining the need for service.

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These rules are intended to implement Iowa Code section 249A.4.

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CERTIFICATE OF NEED PROGRAM
CHAPTER 123
CERTIFICATE OF NEED PROGRAM

Chapter rescission date pursuant to Iowa Code section 17A.7: 7/1/31

441—123.1(135) Definitions. For purposes of this chapter, the following definitions apply:

“Long-term (acute) care hospital” means a hospital that has been approved to participate in the Title XVIII (Medicare) program as a long-term care hospital-prospective payment system (LTCH-PPS) hospital in accordance with 42 CFR Part 412 as amended to August 1, 2025.

“Radiation therapy service applying ionizing radiation for the treatment of malignant disease using megavoltage external beam equipment,” as the term applies to new or changed institutional health service in Iowa Code section 135.61(17)“m”(4), means the initiation or expansion of this service.

[ARC 0320D, IAB 5/27/26, effective 7/1/26]

441—123.2(135) Letter of intent.

123.2(1) Before applying for a certificate of need, the sponsor of a proposed new institutional health service or changed institutional health service will electronically submit a letter of intent meeting the criteria noted in Iowa Code section 135.64(1).

123.2(2) The department will make available on the certificate of need website all criteria and standards pertinent to an application.

123.2(3) A letter of intent received by the department is valid for a period of one year from the date of receipt by the department. The sponsor may renew the validity of a letter of intent by providing written notification to the department prior to the one-year expiration date.

[ARC 0320D, IAB 5/27/26, effective 7/1/26]

441—123.3(135) Determination of reviewability. A sponsor of a proposed project may submit a written request for a determination of reviewability as to whether the project requires a certificate of need.

123.3(1) If it is determined that a certificate of need is required, the department will notify the sponsor and the request for nonreviewability will be considered the letter of intent for purposes of subrule 123.2(2).

123.3(2) If it is determined that a certificate of need is not required, the department will notify the sponsor of the determination of nonreviewability.

[ARC 0320D, IAB 5/27/26, effective 7/1/26]

441—123.4(135) Submission of application.

123.4(1) Application form.

a. A sponsor of a proposed project for a new or changed institutional health service will submit to the department an application for certificate of need using the appropriate application form found on the certificate of need website. All information requested in the application form is required in the absence of a waiver by the department.

b. An original application and all attachments shall be submitted electronically.

c. The department will establish and maintain electronic files on each application.

123.4(2) The application fee specified in Iowa Code section 135.62(1) is based on the total cost of the project, including site costs, land improvements, facility costs, movable equipment, and financing costs.

a. The fee for leased or donated new institutional health services is calculated in the same manner as if the new institutional health services were purchased.

(1) The leased equipment fee is based on total value of the lease, plus sales tax, delivery and installation.

(2) The lease of space includes the cost of a one-year lease payment for the space, in addition to other costs associated with the project.

(3) Financing costs are not applicable on leases or cash purchases.

b. The application fee will be refunded by the department for any application that is voluntarily withdrawn from the review process in the amounts specified in Iowa Code section 135.62(1).

c. For purposes of this subrule and Iowa Code section 135.62(1), “submission” means the day the application is received by the department.

123.4(3) The notice of an accepted application issued pursuant to Iowa Code section 135.65(2) will inform the applicant and affected persons of the deadlines for the electronic submission to the department of written statements or other materials.

[ARC 0320D, IAB 5/27/26, effective 7/1/26]

441—123.5(135) Organizational procedures.

123.5(1) The department will evaluate the application against the criteria specified in Iowa Code section 135.63.

123.5(2) Public comments on an application.

a. The department will receive written public comments on an application during a time frame prescribed by the department for each application. Oral comments will be received at a public hearing set by the department.

b. Public hearings conducted pursuant to Iowa Code section 135.65(3) “b” are not contested cases.

[ARC 0320D, IAB 5/27/26, effective 7/1/26]

441—123.6(135) Summary review. Summary review may be utilized at the discretion of the department pursuant to Iowa Code section 135.66. An applicant requesting a summary review will abide by the following procedures:

123.6(1) An applicant will electronically submit a written request for summary review and a copy of the application and all attachments. An applicant is not required to submit a letter of intent pursuant to Iowa Code section 135.64 prior to submitting a written request for a summary review.

123.6(2) The eligibility of an application for summary review pursuant to Iowa Code section 135.66 does not mandate or require such review. The department will make the decision as to whether an application will be reviewed in the summary review process.

123.6(3) Upon receipt of a written request for summary review, an application, and the fee required by Iowa Code section 135.62(1), the department will notify the applicant in writing within 15 calendar days if the application is complete and if a summary review will be granted.

123.6(4) If an application is deemed incomplete, the department will state specifically in writing what information is needed to make the application complete.

123.6(5) If the department notifies an applicant that a summary review will not be performed, this decision is binding on the applicant and the application will be entered into the formal review process on the date of written notice that such application will not be reviewed summarily.

123.6(6) A summary review of an application for a certificate of need will be completed within 60 calendar days of the acceptance of an application by the department. Summary review will follow the process outlined on the department’s website.

123.6(7) At any time during the summary review process, an application may be withdrawn without prejudice from the process. An applicant may then submit the application for a formal 90-day review.

[ARC 0320D, IAB 5/27/26, effective 7/1/26]

441—123.7(135) Extension of review time.

123.7(1) A formal review of an application for a certificate of need pursuant to Iowa Code section 135.65 may be extended by the department on the basis of any of the following criteria:

a. In order to review competing applications simultaneously;

b. In the case of technologically innovative equipment, to obtain additional information necessary to evaluate the proposal. The department will specify in writing such additional information as necessary;

c. At the request of an applicant;

d. At the request of the department in order to allow additional time for deliberation on all evidence present. The department will specify the time of the delay and the date on which the final decision will be rendered.

123.7(2) An extension by the department made pursuant to subrule 123.7(1) will in no case be more than 60 calendar days beyond the time a decision is required under Iowa Code section 135.68 unless the applicant and the department agree.

123.7(3) Where none of the provisions of subrule 123.7(1) are applicable and where an application will be automatically denied because of the expiration of time required by Iowa Code section 135.68 for the issuance of a written decision by the department, the department will notify the applicant of the likelihood of an automatic denial and will ask the applicant to request in writing an extension of the review time.

[ARC 0320D, IAB 5/27/26, effective 7/1/26]

441—123.8(135) Rehearing of certificate of need decision.

123.8(1) An applicant or any affected person who has participated or sought unsuccessfully to participate in the formal review procedure prescribed in Iowa Code section 135.65 may, for good cause shown, file an application for rehearing in writing with the department stating the specific grounds therefor and the relief sought within 20 calendar days after the date of the issuance of the final decision on an application for certificate of need.

123.8(2) Grounds for rehearing include but are not limited to:

a. New significant, relevant information that was unavailable at the date of the hearing;

b. Significant changes in factors or circumstances relied upon by the department in reaching its decision;

c. Demonstration that the department has materially failed to follow its adopted procedures in reaching its decision; or

d. Such other bases as the department determines constitute good cause.

123.8(3) An application for rehearing is deemed to have been denied unless the department grants the application in writing within 20 calendar days after its filing.

123.8(4) If the application for rehearing is granted, the department may issue an order modifying the initial final order. At the department's discretion, public hearing may be granted on the application for rehearing and notice will be provided ten calendar days prior to the rehearing to the person applying for rehearing, the applicant and other affected persons upon request.

123.8(5) The department will issue the final decision on rehearing, stating the basis for its decision, within 60 calendar days after the application for rehearing was granted or 60 calendar days after public hearing or rehearing, whichever is later.

123.8(6) If a rehearing is not requested or an affected party remains dissatisfied after the request for rehearing, an appeal may be taken in the manner provided by Iowa Code chapter 17A. A request for rehearing is not required prior to appeal under Iowa Code section 17A.19.

[ARC 0320D, IAB 5/27/26, effective 7/1/26]

441—123.9(135) Finality. The certificate of need application process is continuous beginning with submission of a letter of intent or request for waiver of a letter of intent through issuance of a final decision by the department subject to judicial review under Iowa Code chapter 17A.

123.9(1) The following stages of the process are intermediate and subject to judicial review only to the extent the stages meet criteria for intermediate review under Iowa Code section 17A.19:

a. A decision by the department pursuant to rule 441—123.3(135) that a proposed project does not require a certificate of need;

b. A decision by the department to waive submission of the letter of intent and substitute summary review; and

c. The rejection of an application by the department that fails to provide all information required under Iowa Code section 135.62(1).

123.9(2) The following stages of the process are final decisions subject to judicial review as final agency action under Iowa Code section 17A.19:

a. A decision by the department to disallow summary review;

b. A decision by the department that a proposed project does not require a certificate of need;

c. A decision by the department to approve or deny an application;

d. The department's final decision on an application for rehearing; and

e. A decision by the department to revoke a certificate of need pursuant to rule 441—123.10(135).

[ARC 0320D, IAB 5/27/26, effective 7/1/26]

441—123.10(135) Request for extension of certificate.

123.10(1) A request by an applicant for an extension of a certificate of need will be filed with the department using the form available on the certificate of need website no later than 30 days prior to the expiration of the certificate of need.

123.10(2) When an extension has been requested, the department will approve or deny the request prior to expiration of the certification. The certificate of need may be revoked by the department at the end of the certification period for insufficient progress in developing the project.

123.10(3) If an extension is denied, an applicant has the right to appeal under the provisions of Iowa Code section 135.69.

[ARC 0320D, IAB 5/27/26, effective 7/1/26]

441—123.11(135) Application changes after approval.

123.11(1) Once a project has been approved by the department, no changes that vary from or alter the number of approved beds, the approved services or the approved cost by an amount indicated in subrule 123.11(2) may be made unless requested by the applicant and approved by the department. Requests should be made in writing and filed with the department electronically.

123.11(2) An increase in the actual cost of the project over and above that originally approved will automatically generate review by the department if the increase exceeds the originally approved amount by:

a. Fifteen percent for projects up to \$999,999.99;

b. Twelve percent for projects from \$1 million to \$4,999,999.99;

c. Eight percent for projects \$5 million and over.

An increase in the approved cost that falls below the above percentages will be reported to the department.

123.11(3) Failure to notify and receive permission of the department to change the project as originally approved may result in the imposition of sanctions as provided in Iowa Code section 135.72. The department may make a recommendation regarding the imposition of a sanction and the amount of the fine to be imposed.

[ARC 0320D, IAB 5/27/26, effective 7/1/26]

441—123.12(135) Sanctions. Hearings to determine class I or class II violations pursuant to Iowa Code section 135.72 will be conducted in accordance with 441—Chapter 7.

[ARC 0320D, IAB 5/27/26, effective 7/1/26]

These rules are intended to implement Iowa Code sections 135.61 through 135.78.

[Filed ARC 0320D (Amended Notice ARC 0175D, IAB 4/1/26; Notice ARC 9796C, IAB 12/10/25),
IAB 5/27/26, effective 7/1/26]

CHAPTER 124
STANDARDS FOR CERTIFICATE OF NEED REVIEW

Chapter rescission date pursuant to Iowa Code section 17A.7: 7/1/31

441—124.1(135) Cardiac catheterization and cardiovascular surgery standards.

124.1(1) Purpose and scope.

a. These standards are measures of some of those criteria found in Iowa Code section 135.63(1)“a” through “q” and 135.63(3). Criteria that are measured by a standard are cited in parentheses following each standard.

b. Certificate of need applications that are to be evaluated against these cardiac catheterization and cardiovascular surgery standards include:

- (1) Proposals to commence or expand capacity to perform cardiac catheterization.
- (2) Proposals to add new or replace cardiovascular surgery services.
- (3) Any other applications that relate to cardiac catheterization or cardiovascular surgery.

124.1(2) Definitions. The following definitions apply to the terms used in this rule:

“*Adult cardiac catheterization laboratory*” means a diagnostic facility exclusively for intracardiac or coronary artery catheterization on adults.

“*Adult cardiovascular surgery*” means cardiovascular surgery exclusively for adults.

“*Angiocardiography*” means the recording of moving X-ray images (fluoroscopic images) of the heart and great vessels. After injection of radiopaque chemicals, moving X-rays of the chemical’s flow are projected on a screen called a fluoroscope. Moving pictures (cineangiocardiology) or still pictures in sequence (serialography) may be recorded of the X-ray image.

“*Angiography*” means the photographic recording of X-ray or radiologic images of blood vessels in any part of the body—the heart, the head, the great vessels, the kidney, etc. In the procedure, blood vessels are injected with a radiopaque chemical. Immediately following injection, X-rays are employed to image the path of the injected chemical. These X-ray images are then photographically recorded.

“*Cardiovascular surgery*” means the services associated with and surgery performed for congenital or acquired diseases of the heart, great vessels, or pericardium, including the placement of transvenous and epicardial pacemakers.

“*Closed heart surgery*” means cardiovascular surgery in which a small incision and repairs are made without direct vision of the area.

“*Coronary artery catheterization*” means a diagnostic study of the coronary arteries in which a small catheter passes through an artery in the leg, neck or arm into a coronary artery orifice. Intravascular pressure measurements are taken, and angiography of the coronary arteries is performed. Catheterization and cineangiocardiology of the left ventricle are an integral part of this procedure.

“*Coronary artery surgery*” means surgery to correct inadequate blood flow to the heart using revascularization techniques to bypass significantly obstructed coronary artery lesions.

“*Intracardiac*” means a diagnostic study of the heart, pulmonary arteries, or both in which a small catheter passes through a vein or artery in the neck, leg or arm and advances into the great vessels, the heart or the pulmonary arteries. Through this procedure, one can measure pressure within the heart and in adjacent veins and arteries, collect blood samples for blood gas analysis and inject radiopaque material, and visualize cardiac and vessel anatomy. The procedure permits detection of congenital and acquired heart abnormalities, the study of ventricular function, the estimation of the orifice size, the placement of pacemakers, etc. Cardiac catheterization is incomplete without cineangiography, intracardiac pressure measurements, blood gas analysis and the ability to diagnose intracardiac shunts.

“*Open heart surgery*” means cardiovascular surgery in which an incision of sufficient size is made to allow direct vision of the area. Open heart surgery requires temporary use of a heart-lung (cardiopulmonary bypass) machine since blood flow through the heart is greatly reduced or stopped altogether.

“Pediatric cardiac catheterization laboratory” means the same as adult cardiac catheterization laboratory, except exclusively for children and infants.

“Pediatric cardiovascular surgery” means cardiovascular surgery exclusively for infants and children.

124.1(3) Availability of services.

a. Minimum utilization—cardiovascular surgery (Iowa Code section 135.63(1) “c,” “g,” and “h”).

(1) Adult cardiovascular surgical programs should project an annual minimum rate of over 200, or no approval will be granted. Higher case loads over 200 per annum are encouraged.

(2) Pediatric cardiovascular surgical units should project a minimum of 100 pediatric heart operations after the first year, at least 75 of which must be open heart procedures.

(3) Combined adult and pediatric cardiovascular surgery units should project the minimum projected annual rates for both adult and pediatric surgery.

(4) An applicant should project utilization of cardiovascular surgery, catheterization and cardiac care units based upon service area population demographics, current regional or national utilization rates of the service, disease incidence and prevalence rates, current cardiac care treatment modes, and in consideration of those adult cardiovascular surgery units currently operating in Iowa and bordering states within the project’s service area.

b. Expansions—cardiovascular surgery (Iowa Code section 135.63(1) “c,” “d,” “e,” “g,” and “h”).

(1) There should be no additional adult cardiovascular surgery units initiated unless each existing unit within the project’s service area is operating at a minimum of 200 open heart surgery cases per year.

(2) There should be no additional pediatric cardiovascular surgery units initiated unless each existing unit within the project’s service area is operating at 100 surgeries per year. If one team serves more than one institution, the numbers for those institutions should be combined.

(3) If the annual utilization of the other cardiovascular surgery units within the area is below the levels noted above, future utilization above that current level must be reasonably projected or reasons for permanently utilizing the equipment below the level must be demonstrated.

(4) An applicant will demonstrate that an attempt was made to determine with the cooperation of existing providers whether such a reduction would occur. Existing providers of consequence are generally within two hours’ surface travel time for adult services and within three hours’ surface travel time for pediatric services.

c. Minimum utilization—cardiac catheterization (Iowa Code section 135.63(1) “c,” “d,” “g,” and “h”).

(1) Adult cardiac catheterization laboratories should be projected to operate at a minimum of 300 catheterizations per annum.

(2) Pediatric catheterization laboratory units should project a minimum of 150 catheterizations per annum.

(3) Combined units should meet each of the adult and pediatric standards.

(4) An applicant should project utilization of cardiac catheterization units based upon service area population demographics, current regional or national utilization rates of the service, disease incidence and prevalence rates, current cardiac care treatment modes, and in consideration of those adult cardiovascular surgery units currently operating in Iowa and bordering states within the project’s service area.

d. Expansions—cardiac catheterizations (Iowa Code section 135.63(1) “c,” “d,” “e,” “g,” and “h”).

(1) There should be no additional adult cardiac catheterization unit opened unless the number of studies per year in each existing unit within the project’s service area is greater than 300. No additional pediatric unit should be opened unless the number of studies per year in each existing unit within the project’s services area is greater than 150.

(2) If the annual utilization of the other cardiovascular surgery units within the area is below the levels noted above, future utilization above that current level must be reasonably projected or reasons for permanently utilizing the equipment below the level must be demonstrated.

(3) An applicant must demonstrate that an attempt was made to determine with the cooperation of existing providers whether such a reduction would occur. Existing providers of consequence are those within two hours' surface travel time for adults or three hours' surface travel time for pediatrics.

124.1(4) Costs.

a. Financial feasibility. (Iowa Code section 135.63(1) "f," "i," and "p") Cardiovascular surgery and catheterization equipment and associated remodeling or construction should be depreciated over a period consistent with generally accepted accounting standards.

b. Cost-effectiveness. Proposed new or replacement cardiac catheterization laboratories cost per catheterization and cardiovascular surgery services estimated costs per surgery should, when compared to their peers, demonstrate cost-effectiveness.

124.1(5) Accessibility. (Iowa Code section 135.63(1) "c" and "d")

a. Cardiovascular surgery units and cardiac catheterization labs should meet the needs of the communities that the units and labs are meant to serve.

b. Cardiac catheterization and cardiovascular surgery service should be provided regardless of ability to pay in consideration of those programs available in the state that serve the medically indigent.

124.1(6) Quality. (Iowa Code section 135.63(1) "i" and "k")

a. Each surgery unit and cardiac catheterization lab shall demonstrate a reasonable set of criteria that are used in selecting appropriate candidates for surgery and catheterization.

b. Staffing minimums.

(1) The open heart surgery team should minimally consist of:

1. At least two certified or board-eligible cardiovascular surgeons for the first 75 to 130 pediatric open heart surgeries. If pediatric surgery is performed, one surgeon must have special training and experience in surgery for congenital cardiac defects.

2. Board-certified or board-eligible adult or pediatric cardiologist(s). The latter only if pediatric surgery is performed, the former only if adult surgery is performed.

3. Board-certified or board-eligible anesthesiologist with special training in the management of cardiovascular cases' respiratory care.

4. Radiologist trained in the cardiovascular field.

5. Pathologist familiar with cardiac problems.

6. Surgical nursing staff specially trained in heart disease.

7. Cardiopulmonary bypass pump technicians.

8. Other ancillary staff as needed.

(2) Each applicant will document that the proposed surgery unit can be so staffed when completed and operational.

c. Equipment and facilities. An applicant seeking to provide cardiovascular surgery should demonstrate that the following support services will be available:

(1) General X-ray diagnostic facilities and facilities for emergency X-rays on a 24-hour basis.

(2) A cardiac catheterization laboratory or angiography lab available on a 24-hour basis.

(3) A cardiographics laboratory with facilities for recording the following tests: EKG, vector cardiogram, phonocardiogram, echocardiogram, and exercise stress testing.

(4) A supporting blood bank and hematology laboratory.

(5) A microbiology laboratory.

d. Cardiac catheterization labs serving infants and children should have biplane angiographic equipment, either cineangiographic or cut film. Pediatric cardiac catheterization labs should be supervised by board-certified or board-eligible pediatric cardiologists; adult cardiac catheterization labs should be supervised by a board-certified or board-eligible adult cardiologist.

124.1(7) Continuity. (Iowa Code section 135.63(1) "g," "h," "i," and "k")

- a.* An applicant should demonstrate that an attempt was made to solicit letters of support from area hospitals and physicians to indicate a community need.
- b.* An applicant should provide documentation that emergency medical transport services will be available.
- c.* Institutions providing cardiovascular surgery services should include mechanisms for comprehensive medical followup, including adequate medical records exchange.

124.1(8) Acceptability. (Iowa Code section 135.63(1)) Facilities with cardiovascular surgery and cardiac catheterization indicate a willingness to observe and respect the rights of patients.

[ARC 0320D, IAB 5/27/26, effective 7/1/26]

441—124.2(135) Radiation therapy standards.

124.2(1) Purpose and scope.

a. These standards provide guidelines to assist the department in applying those criteria in Iowa Code section 135.63(1) “a” through “r” and 135.63(3). Criteria that are measured by a standard are cited in parentheses following each standard.

b. Certificate of need applications that are to be evaluated against these radiation therapy standards include:

- (1) Proposals to commence or expand the kind or capacity of megavoltage radiation therapy services.
- (2) Proposals to replace a megavoltage radiation therapy unit.
- (3) Any other applications that relate to megavoltage radiation therapy.

124.2(2) Definitions. The following definitions apply to the terms used in this rule:

“*Computed tomography*” or “*CT*” means an imaging method in which a cross-sectional image of the structures in a body plane is reconstructed by a computer program from the X-ray absorption of beams projected through the body in the image plane.

“*Conjoint radiation oncology center*” or “*cancer center*” means a multi-institution, multidisciplinary network to provide radiation therapy for cancer patients. Integration of patient care management, common utilization of personnel and equipment, and a single system of records between center institutions ensures optimal care regardless of entry portal.

“*Dosimetrist*” means a staff member who calculates, verifies, and develops treatment plans for the radiation dose distributions that will be delivered to patients. The dosimetrist is an essential member of the treatment planning team and works closely with radiation oncologists and radiation physicists.

“*Megavoltage therapy*” means the use of ionizing radiation in excess of 1 million electron volts. Energies above 1 million electron volts cause considerably less skin damage, increase depth dose markedly, and result in much less scatter from the therapeutic beam. Megavoltage machines are classified as follows:

1. Electron accelerator. A machine such as a linear accelerator that uses a supply of electrons, which are accelerated into high-energy beams. These electron beams are either caused to strike a target resulting in high-energy X-ray production or are used themselves as the treatment beam. Electron accelerators generate over 1 million electron volts.

2. Heavy particle accelerator. A machine such as a cyclotron that produces beams of high-energy particles such as protons, neutrons, pions, carbon ions, or other heavy ions with masses greater than that of an electron.

3. Isotope sources (gamma ray teletherapy units). Cobalt 60 units—emit gamma rays of approximately 1.2 million electron volts.

“*Megavoltage therapy unit*” means a piece of megavoltage therapeutic radiologic equipment that provides megavoltage therapy.

“*New occurrence*” means a course of treatment for a new occurrence on a given patient at a given radiation therapy facility. First-time radiation therapy at a new facility is based on each round of treatment.

“Radiation modality” means the method of applying ionizing radiation in the treatment of patients with malignant disease using megavoltage external beam equipment.

“Radiation oncologist” means a physician authorized user trained in accordance with rule 641—42.5(136C).

“Radiation therapy facility” or *“facility”* means the physical space that houses a megavoltage therapy unit and accompanying support equipment.

“Radiation therapy physicist” means an individual who works closely with radiation oncologists and is responsible for the safe and accurate delivery of radiation to patients. A radiation therapy physicist conducts quality control programs for the equipment and procedures and calibrates the equipment. A radiation therapy physicist shall practice in accordance with rule 641—42.6(136C).

“Radiation therapy technologist” means an individual who possesses an Iowa permit to practice as a radiation therapist in accordance with rule 641—38.4(136C).

“Service area” means the county in which the facility is located and any other counties from which an applicant expects to draw patients with a cancer diagnosis who need radiation therapy treatment.

“Simulation” means the precise mock-up of a patient treatment with an apparatus that uses planar X-rays, a magnetic resonance imaging device, or a computed tomography scanner, which is used in reproducing the two-dimensional or three-dimensional internal or external geometry to the patient, for use in treatment planning and delivery.

“Superficial X-ray therapy” means the use of a conventional X-ray machine, which generates X-rays of up to 150 kilovolts (kv), to treat superficial lesions, such as skin cancer.

“Treatment” means radiation fields applied in a single patient visit fraction or delivery session.

124.2(3) Availability.

a. Minimum utilization. (Iowa Code section 135.63(1) “c,” “g,” and “h”)

(1) A megavoltage radiation therapy unit and cobalt units should treat at least 250 new occurrences annually within three years after initiation of the service.

(2) The expected number of new occurrences needing megavoltage radiation therapy annually in a service area should be calculated as follows:

1. Multiply the service area population by 0.00582 (5.82/1,000 population was the mean cancer incidence rate in 2017 in Iowa as filed by the Surveillance, Epidemiology, and End Results (SEER) Program).

2. Multiply this product by 0.5 (50 percent of all new occurrences receive radiation therapy).

(3) The expected volume of utilization sufficient to support the need for a new megavoltage therapy unit should be calculated as follows: Each unit shall provide a minimum of 5,000 treatments per annum. Megavoltage treatments should be projected by multiplying the number of projected new occurrences needing megavoltage therapy by 20, which will result in no fewer than 5,000 treatments per annum.

(4) An applicant shall account for other providers of radiation therapy in the service area, including but not limited to factors such as technological capability and quality. An applicant shall address in the applicant’s application other providers and the impact on those providers in the service area and compare technological capability and quality.

(5) An applicant should provide a map of the expected service area.

(6) Institutions that form a conjoint oncology center should have at least 500 new occurrences annually.

b. Simulator availability. A simulator should be available within a radiation oncology department.

124.2(4) Accessibility. (Iowa Code section 135.63(1) “c” and “d”) Radiation therapy services should be provided regardless of ability to pay in consideration of those programs available in the state that serve the medically indigent.

124.2(5) Quality. (Iowa Code section 135.63(1) “i” and “k”)

a. Minimum staffing requirements for radiation therapy facilities. Each facility:

- (1) Will have the services of at least one radiation oncologist.
- (2) Will have the services of at least one radiation therapy physicist.
- (3) Will have the services of radiation therapy technologists that should be staffed at a level of two technologists per megavoltage unit.
- (4) Should have the services of nurses.
- (5) Should have the services of at least one dosimetrist.
- (6) Should have the services of one radiation therapist or radiation technologist competent to operate a CT simulator.
- (7) Should offer psychosocial counseling services and nutritional counseling.
 - b. Minimum staffing requirements for conjoint centers. Each center:
 - (1) Will have at least two cancer biologists available.
 - (2) Will have one radiation technologist available for each simulator.
 - (3) Should have a source of continuing education to reach participating community referral hospitals and physicians.
 - (4) Should have a unified training program in radiation therapy for radiation oncologists.
 - c. The long-range plans for radiation therapy services shall be submitted to the department.
 - d. Multidisciplinary tumor boards should be established in all institutions housing megavoltage machines.

124.2(6) Continuity. (Iowa Code section 135.63(1) “g,” “h,” “i,” and “k”) An applicant should demonstrate that an attempt was made to solicit letters and establish referral agreements from area hospitals and physicians to indicate their willingness to participate in a cooperative endeavor to refer to the proposed service.

[ARC 0320D, IAB 5/27/26, effective 7/1/26]

441—124.3(135) Computerized tomography standards.

124.3(1) Purpose and scope.

- a. These standards are measures of some of those criteria in Iowa Code section 135.63(1) “a” through “l.” Criteria that are measured by a standard are cited in parentheses following each standard.
- b. Certificate of need applications that are to be evaluated against these computerized tomography standards include:

- (1) Proposals to commence or expand the capacity of computerized tomography services.
- (2) Any other applications that relate to computerized tomography services.

124.3(2) Definitions. The following definitions apply to the terms used in this rule:

“*Active oncology service*” means full, multidisciplinary cancer care, provided by a medical team that would include: surgery, gynecology, medical oncology, radiation oncology, pathology, diagnostic radiology and nuclear medicine. The surgery specialties that might be available would include: thoracic, abdominal, genitourinary and gynecological. The active oncology staff would include those specialists with training in oncology, hematology, and pathology and who spend at least half of their time at the institution.

“*Applicant*” means a facility or a consortium of facilities within an area or a physician or group of physicians.

“*Chemotherapy service*” means the treatment of cancer by chemical agents.

“*Computerized tomographic (CT) scanner*” means a diagnostic tool that rotates around the body and that sends X-ray beams through the body or brain. The X-ray beams that emerge from the body or brain are absorbed by a detector. Differences in the amount of X-rays absorbed by the detector indicate differences in tissue density. As the scanner rotates, it takes many images of a volume or cross-section. The images on the detector are transmitted to a computer that displays on a monitor a reconstructed cross-sectional slice or volume. Contrast media is often injected to alter absorption of the detector. If the scan is repeated, it is called enhancement. Studies of the heart, arteries and veins may be done with contrast only.

“*CT consortia*” means a cooperative venture in which two or more institutions form a separate entity that is created for the purpose of owning, leasing, planning for, and maintaining the use of the scanner. Each facility in the consortium maintains its autonomy for all other services.

“*Emergency medical service (EMS) level II trauma service*” means the level of various services and staffing that qualify a facility to be designated by the department, using the facilities categorization criteria of such services that is in effect on the date of the enactment of this standard.

“*Enhanced scan*” means a scan performed on a patient who has been administered a contrast medium so that specific organs or areas of the body will be displayed more distinctly on the scan image.

“*General imaging procedures*” means a radiological diagnostic procedure performed on an X-ray machine or similar radiological diagnostic instrument.

“*Head scanner*” means a scanner capable of imaging only the brain and structures adjacent to the head.

“*Minimum shared-market area for a scanner*” (hereafter referred to as “area”) means the smallest geographic area within which any scanner installation is judged to affect the utilization rate of any other scanner in the community (as defined by the U.S. Bureau of the Census) or a standard metropolitan statistical area (where an area is so designated).

“*Radiotherapy service*” means the therapeutic application of megavoltage radiation, using a linear accelerator or cobalt unit. The availability of such service at a hospital would necessitate personnel trained in the therapeutic application of radiology.

“*Shared service agreement*” means a multi-institutional arrangement for coordination or consolidation of services or sharing of support services. Among the various types of arrangements are referred services, purchased or joint contract services, multisponsored services and regional services.

“*Whole body scanner*” means a scanner capable of imaging the entire body.

124.3(3) Determination of need.

a. An applicant who does not have a scanner or an applicant who has a scanner and seeks a certificate for one or more additional scanners.

(1) An applicant in areas with no other scanners.

1. An applicant must have performed at least 30,000 general imaging procedures during the past calendar year or 12 months, or

2. An applicant must demonstrate that during the past calendar year or 12 months, the applicant has performed diagnostic procedures equivalent to 1,500 head equivalent CTs (HECTs), using the following: 100 percent of the number of patients referred to other facilities for CT diagnosis $\times$ 1.75 (in the case of head scans) and 2.75 (in the case of body scans).

(2) An applicant in an area with one or more scanners.

1. An applicant must meet the requirement of need described in subparagraph 124.4(3) “a”(1), and

2. The average level of utilization for scanners within the area was at least 3,000 HECTs (plus or minus 10 percent) for the past calendar year or 12 months. The average level of utilization will be determined by adding the number of HECTs performed during the period at all area facilities divided by the number of facilities.

3. University of Iowa Health Care is specifically exempted from consideration under numbered paragraph 124.3(3) “a”(2) “2” because it has a service area that encompasses the entire state and adjoining states. The utilization statistics for scanners at the University of Nebraska Medical Center and Creighton University Medical Center – Bergan Mercy (both in Omaha) will not affect the need for scanners at hospitals in Council Bluffs.

b. Replacement scanners—applicant who currently has a scanner.

(1) An applicant seeking to replace a scanner with another scanner, head or body.

1. An applicant must demonstrate that the applicant’s use of the applicant’s current scanner was at least at the operating capacity level during the last calendar year or 12 months, or

2. An applicant must demonstrate that the applicant's use of the applicant's current scanner was at least below the operating capacity level, but above the 1,500 CT scan level, and the applicant must demonstrate reasons for permanently utilizing the applicant's scanner below operating capacity level and demonstrate that discontinuation of the applicant's scanner service would impair the applicant's ability to respond to the emergency needs of the area. Reasons for utilizing the scanner below the capacity should include a unique patient or procedure mix that would define the capacity level differently for the applicant.

(2) Reserved.

124.3(4) *Costs and financial feasibility.* (Iowa Code section 135.63(1) "f," "i," and "p")

a. CT scanners should be depreciated over a period of not less than seven years. Remodeling shall be depreciated as appropriate by generally accepted accounting principles.

b. Cost-effectiveness. An applicant should demonstrate for the applicant and the health care system that the most cost-effective method of providing CT services has been chosen. A proposed new and replacement CT scanner's cost per CT scan should, when compared to the applicant's peers, demonstrate cost-effectiveness.

124.3(5) *Accessibility.* (Iowa Code section 135.63(1) "c" and "d")

a. All scanners must be available to meet the needs of the communities the scanners are meant to serve.

b. Services should be provided to all patients regardless of the patients' ability to pay, taking into consideration the availability of those programs available in the state that serve the medically indigent.

c. An applicant will demonstrate a willingness to accept referrals for CT services from all area physicians.

124.3(6) *Quality.* (Iowa Code section 135.63(1) "i" and "k")

a. Data on use and costs of the CT scanners should be submitted to the Iowa department of health and human services as a condition of approval. (Iowa Code section 135.63(1) "a" and "h")

b. All scanners.

(1) An applicant must demonstrate that the applicant has on its staff or will acquire on its staff a full-time diagnostic radiologist trained in the use of the CT scanner or other physicians with comparable training and expertise.

(2) An applicant must document that the applicant has on its medical staff individuals who are qualified to operate a scanner and interpret and act upon the diagnostic results. Such documentation may include reference to board certification, apprenticeship, academic credentials or such other qualifications that would prompt a medical staff to accept the responsibility for offering this new service. An applicant that intends to acquire staff with the desired expertise should provide signed letters of intent from the incoming medical personnel. An applicant that intends to upgrade the specialty skills of its staff should document a plan for training its current staff in the use of CT scanners.

(3) An applicant should have a complement of other diagnostic modalities available. An applicant seeking body scanners should also have available ultrasound and conventional X-ray services.

(4) An applicant should have the facilities for treating the conditions diagnosed by imaging with the scanner or should demonstrate referral agreements with treatment facilities in the event that the scanner will be used as a screening device.

(5) An applicant should have on its staff or available on a consultative basis the services of a biomedical engineer or medical physicist with special training in CT applications. These functions may also be provided by contract with the scanner manufacturer.

124.3(7) *Continuity.* (Iowa Code section 135.63(1) "g," "h," "i," and "k")

a. An applicant should demonstrate that an attempt was made to solicit letters of support from area hospitals and physicians to indicate a community need for the proposed service.

b. An applicant should provide documentation that emergency medical transport services will be available.

c. An applicant should demonstrate an emphasis on the availability of outpatient CT procedures and that an appropriate percentage of all CT procedures will be done on an outpatient basis.

124.3(8) Acceptability. (Iowa Code section 135.63(1)“k”) Providers of CT services should indicate a willingness to observe the rights of patients.

[ARC 0320D, IAB 5/27/26, effective 7/1/26]

441—124.4(135) Long-term care.

124.4(1) Purpose and scope.

a. These standards are measures of criteria found in Iowa Code section 135.63(1)“a” through “g.” Criteria that are measured by a standard are cited in parentheses following each standard.

b. Certificate of need applications that are to be evaluated against these standards include applications to:

(1) Construct, develop, offer new, modernize, replace, renovate, or relocate intermediate care or skilled nursing care beds in nursing homes or hospitals.

(2) Expand bed capacity in intermediate care or skilled nursing care facilities or designated units in hospitals.

124.4(2) Definitions. The following definitions apply to the terms used in this rule:

“*Intermediate care facility*” or “*ICF*” means any institution, place, building, or agency providing for a period exceeding 24 consecutive hours accommodation, board, and nursing services, the need for which is certified by a physician, to three or more individuals, not related to the administrator or owner thereof within the third degree of consanguinity, who by reason of illness, disease, or physical or mental infirmity require nursing services that can be provided only under the direction of a registered nurse or a licensed practical nurse.

“*Skilled nursing facility*” or “*SNF*” means any institution, place, building, or agency providing for a period exceeding 24 consecutive hours accommodation, board, and nursing services, the need for which is certified by a physician, to three or more individuals not related to the administrator or owner thereof within the third degree of consanguinity who by reason of illness, disease, or physical or mental infirmity require continuous nursing care services and related medical services but do not require hospital care. The nursing care services provided must be under the direction of a registered nurse on a 24-hour-per-day basis.

124.4(3) Availability and need. (Iowa Code section 135.63(1)“c,” “d,” “e,” “g,” and “h”)

a. The following formula will be used as a means of projecting the approximate number of beds needed by level of care (intermediate or skilled nursing care) to serve the projected population one year into the future using county-level characteristics:

(1) County-level bed need = County-level bed-days / days in time period

County-level bed-days = exp(Linear Predictor)

Linear Predictor = Intercept

+ Weight for Log of Total Population × Log of Total Population

+ Weight for Percent age 65-74 × Percent age 65-74

+ Weight for Percent age 75-84 × Percent age 75-84

+ Weight for Percent age 85 plus × Percent age 85 plus

+ Weight for Level of care × Level of care

+ Weight for Time Trend × Time Trend

+ Weight for Level of care × Time Trend × Level of care × Time Trend

+ Month effect for applicable month

+ County effect for applicable county

(2) For the purposes of using this formula, the lower and upper bounds of the weights for each variable in this section can be found on the department’s website at hhs.iowa.gov/certificate-need-con-program.

(3) Bed need formula projections will consider county of facility, seasonal variation in need, age range of population, future population change projections, and other relevant factors and controls.

(4) The department will review the bed need formula at least every three years.

b. For purposes of comparing “need” to “existing” beds in a given county, the following shall be considered in the calculation of “existing” beds:

(1) ICF and SNF beds licensed at freestanding facilities in the county.

(2) Additional ICF and SNF beds previously approved through certificate of need but not yet licensed.

(3) ICF and SNF beds in designated units in hospitals in the county.

c. The statistical calculation of bed need shall serve as a guideline for the department in reviewing need for the proposed long-term care beds. Other factors that may be considered by the department include but are not limited to:

(1) The availability and utilization of other ICF and SNF services in the county or within an applicant’s service area.

(2) The availability and utilization of other long-term care services in nearby hospitals, such as skilled care available through the swing bed program.

(3) The availability of supportive living arrangements that may or may not be licensed as an RCF.

(4) The availability of home health and other in-home services.

(5) The availability of other services to the elderly.

(6) The availability of ICF and SNF services in neighboring counties.

(7) Utilization by out-of-state residents of facilities in counties bordering other states, where an applicant provides evidence that in-migration of long-term care patients exceeds out-migration to the bordering state.

(8) Programs and services directed at special populations whose needs cannot otherwise be met or whose needs cannot be met cost-effectively at other facilities.

d. In documenting need for a project, an applicant shall identify the service area and target population, including a description of the methodology used by the applicant in determining need for the requested beds and the expected sources of referrals. The applicant shall document that the number of beds requested is appropriate to address the identified need. The applicant shall also identify how the target population is currently being cared for and what hardship is being experienced by the absence of the proposed beds.

124.4(4) *Quality.* (Iowa Code section 135.63(1) “i” and “k”) An applicant shall document that the applicant has contacted the health and safety division of the department of inspections, appeals, and licensing to conform with physical standards, staffing requirements, and other licensing requirements to assess the potential for provision of quality care at the facility. When necessary, the applicant shall attempt to arrange an on-site visit to the facility to determine compliance with physical requirements and shall provide documentation of this site visit or attempts to arrange such a site visit.

124.4(5) *Continuity.* (Iowa Code section 135.63(1) “g,” “h,” and “k”)

a. An applicant shall document the relationship of the facility’s proposed services to other health and long-term care services in the community, such as physician and hospital services, habilitation, rehabilitation, transportation or other services. The facility should be capable of providing or arranging for the provision of a continuum of long-term care services.

b. A facility should be capable of providing or arranging for the provision of a comprehensive program of coordinated patient services. An applicant shall provide evidence of contracts for services, appropriate staffing patterns and ratios, and licensure of personnel as necessary.

124.4(6) *Accessibility and acceptability.* (Iowa Code section 135.63(1) “c” and “d”)

a. Population subgroups that have traditionally been underserved, such as adolescents, the elderly, women, racial minorities, mentally ill, intellectually disabled, and developmentally disabled, should be considered when planning for or reviewing long-term care facilities.

b. An applicant shall document to what extent Medicaid patients will be served by the proposed beds, using past Medicaid utilization as an indicator or, in the case of a new facility, projecting anticipated Medicaid utilization.

124.4(7) *Costs and financial feasibility.* (Iowa Code section 135.63(1) “e,” “f,” “i,” and “p”)

a. An applicant shall identify capital and operating costs associated with the project, identify sources of funding to cover those costs, and demonstrate that the project is financially feasible.

b. Construction costs shall be in line with construction costs of other similar projects.

c. An applicant shall provide budgets for the first three years of operation, including documentation of all assumptions used. The budget shall include anticipated sources of revenue, including the percentage of revenue from private pay, Medicaid, Medicare and other patient revenues.

d. Proposed charges per patient day should be justifiable when compared to current charges of other similarly licensed facilities in an applicant’s service area or other similar facilities elsewhere in the state. If charges are significantly higher or lower, the applicant shall provide a description of proposed programs or services that explain the difference in charges.

These rules are intended to implement Iowa Code section 135.71.

[ARC 0320D, IAB 5/27/26, effective 7/1/26]

441—124.5(135) MRI services standards.

124.5(1) *Purpose and scope.*

a. These standards are measures of some of those criteria in Iowa Code section 135.63(1) “a” through “q.” Criteria that are measured by a standard are cited in parentheses following each standard.

b. Certificate of need applications that are to be evaluated against these standards include:

- (1) Proposals to commence or expand the capacity of magnetic resonance imaging services.
- (2) Proposals to replace a magnetic resonance imaging unit.
- (3) Any other applications that relate to magnetic resonance imaging.

124.5(2) *Definitions.* The following definitions apply to the terms used in this rule:

“Area” means the community or a metropolitan statistical area (as defined by the U.S. Office of Management and Budget and used by the U.S. Census Bureau).

“Computed tomography” or “CT” means an imaging method in which a cross-sectional image of the structures in a body plane is reconstructed by a computer program from the X-ray absorption of beams projected through the body in the image plane.

“CT procedure” means a CT study of a single site of anatomic interest during an individual patient visit.

“Magnetic resonance imaging” or “MRI” means a diagnostic modality that employs a combination of magnetic and radio frequency fields and computers to produce images of body organs and tissues.

“MRI procedure” means each discrete MRI study of one patient.

“MRI unit” means the essential equipment and facility necessary to operate one MRI system.

124.5(3) *Availability and need.* (Iowa Code section 135.63(1) “c,” “d,” “e,” “g,” and “h”)

a. An applicant in an area with no other MRI units. The applicant must document a future utilization of reasonably projected MRI procedure volume for the fiscal year period after projected installation.

b. An applicant in an area with one or more MRI units currently in operation or approved by certificate of need for operation.

(1) An applicant must meet the requirement of need described in paragraph 124.5(3) “a,” and

(2) The other MRI unit(s) within the area must have been operating at a minimum of 2,000 MRI procedures annually (or 500 in three months) or proportionately more if the MRI unit runs more than one ten-hour shift.

(3) If the annual utilization of the other MRI unit(s) within the area has been below 2,000 procedures, future utilization above that current level must be reasonably projected or reasons for permanently utilizing the equipment below the 2,000 procedure level must be demonstrated.

c. An applicant seeking to replace an MRI unit.

(1) An applicant must demonstrate that the existing MRI unit has been operating at the level of at least 3,000 procedures during the most recent annual period.

(2) If an applicant's annual utilization has been below 2,000 procedures, the applicant must reasonably project future utilization above that level or demonstrate reasons for permanently utilizing the equipment below that level.

d. An applicant seeking to add an additional MRI unit.

(1) An applicant must demonstrate that the existing MRI unit(s) has been operating at the level of at least 3,500 procedures during the most recent annual period.

(2) An applicant must demonstrate that the demand significantly exceeds the 2,000 procedures annually.

(3) If an applicant's annual utilization has been below 2,000 procedures, the applicant must reasonably project future utilization above that level or demonstrate reasons for permanently utilizing the equipment below that level.

124.5(4) *Quality and continuity.* (Iowa Code section 135.63(1) "g," "h," "i," and "k")

a. The proposed MRI unit should function as a component of a comprehensive inpatient or outpatient diagnostic service. The proposed MRI unit must have the following modalities on-site or through referral arrangements:

- (1) Ultrasound.
- (2) Computed tomography.
- (3) Angiography.
- (4) Nuclear medicine.
- (5) Conventional radiography.

b. The proposed MRI unit must be located in a facility that has, either in-house or through referral arrangement, the resources necessary to treat most of the conditions diagnosed or confirmed by MRI. The following medical specialties must be available during MRI service hours on-site or by referral arrangements: neurology or neurosurgery, oncology and cardiology.

c. A proposal to provide a new or an expanded MRI must include satisfactory assurances that the services will be offered in a physical environment that conforms to federal standards, manufacturer's specifications, and licensing agencies' requirements.

d. An applicant must provide evidence that the proposed MRI equipment has been certified for clinical use by the U.S. Food and Drug Administration or will be operated under the approval and authority of an institutional review board whose membership is consistent with U.S. Department of Health and Human Services regulations.

e. An applicant for MRI should document that the necessary qualified staff are available to operate the proposed unit. The following minimum staff will be available to the MRI unit:

(1) A board-eligible or board-certified radiologist or any other board-eligible or board-certified licensed physician whose exclusive responsibility for at least a two-year period prior to submission of a certificate of need request has been in the acquisition and interpretation of clinical images. This individual shall have a knowledge of MRI through training, experience, or documented postgraduate education. The individual shall also have training with a functional MRI facility.

(2) Qualified engineering personnel, available to the institution during MRI service hours, with training and experience in the operation and maintenance of the MRI equipment.

(3) Diagnostic radiologic technologists or other certified technologists with expertise in CT or other cross-sectional imaging methods at a staffing level consistent with the hospital's expected MRI service volume.

(4) Other appropriate physicians shall be available during MRI service hours in clinical specialties, such as neurology or neurosurgery, oncology and cardiology.

f. An applicant shall demonstrate how emergencies within the MRI unit will be managed in conformity with accepted medical practice.

124.5(5) *Accessibility and acceptability.* (Iowa Code section 135.63(1) "c" and "d")

a. An MRI facility should have adequate scheduled hours to avoid an excessive backlog of cases and to meet the needs of the communities the scanners are meant to serve.

b. Selection of patients for clinical MRI studies must guarantee equal access to all persons regardless of insurance coverage or ability to pay.

124.5(6) *Costs and financial feasibility.* (Iowa Code section 135.63(1) “*e*,” “*f*,” “*i*,” and “*p*”)

a. An applicant shall identify capital and operating costs associated with the proposed MRI unit, identify sources of funding to cover those costs, and demonstrate that the project is financially feasible.

b. An applicant shall provide budgets for the first three years of operation, including documentation and justification of all assumptions used.

c. An applicant must document its projected average cost per procedure and charge per procedure for the first three years. Charges for an MRI should be reasonably related to service cost and comparable to MRI charges at other facilities in the state.

d. An applicant shall demonstrate that alternatives were considered and the proposed application is the most cost-effective and will accomplish the goals of the project.

[ARC 0320D, IAB 5/27/26, effective 7/1/26]

441—124.6(135) PET services standards.

124.6(1) *Purpose and scope.*

a. These standards are measures of some of those criteria in Iowa Code section 135.63(1) “*a*” through “*q*.” Criteria that are measured by a standard are cited in parentheses following each standard.

b. Certificate of need applications that are to be evaluated against these standards include:

- (1) Proposals to commence or expand the capacity of positron emission tomography services.
- (2) Proposals to replace a positron emission tomography unit.
- (3) Any other applications that relate to positron emission tomography.

124.6(2) *Definitions.* The following definitions apply to the terms used in this rule:

“*Area*” means the community or a metropolitan statistical area (as defined by the U.S. Office of Management and Budget and used by the U.S. Census Bureau).

“*Computed tomography*” or “*CT*” means an imaging method in which a cross-sectional image of the structures in a body plane is reconstructed by a computer program from the X-ray absorption of beams projected through the body in the image plane.

“*Cyclotron*” means an apparatus for accelerating protons or neutrons to high energies by means of a constant magnet and an oscillating electric field.

“*Magnetic resonance imaging*” or “*MRI*” means a diagnostic modality that employs a combination of magnetic and radio frequency fields and computers to produce images of body organs and tissues.

“*PET procedure*” means an image-scanning sequence derived from a single administration of PET, equated with a single injection of the tracer.

“*Positron emission tomography*” or “*PET*” means an imaging method in which positron-emitting radionuclides, which are produced either by a cyclotron or generator, and a nuclear camera are used to create pictures of organ function rather than structure.

“*Radiopharmaceutical*” means a radioactive pharmaceutical used for diagnostic or therapeutic purposes.

“*Single photon emission computed tomography*” or “*SPECT*” means a camera-based imaging system using the radionuclides in the routine practice of nuclear medicine.

124.6(3) *Availability and need.* (Iowa Code section 135.63(1) “*c*,” “*d*,” “*e*,” “*g*,” and “*h*”)

a. An applicant in an area with no other PET units.

(1) An applicant should demonstrate a reasonable potential utilization of a PET unit based on diversified inpatient and outpatient case mix thresholds, including:

1. Intracranial cases.
 - Primary brain tumors: 50 per year.

- Metastasis: 100 per year.
 - Cerebral vascular disease: 200 per year.
 - Organic brain disease and dementia/psychiatric diagnoses (including epilepsy-seizure disorders): 500 per year.
 - Spinal: 100 per year.
2. Cardiovascular cases.
 - Ischemic heart disease (including acute and chronic infarction): 1,200 per year.
 3. Neoplasms (head, neck, thorax (excluding heart), abdomen, pelvic, prostate and musculoskeletal): 1,300 per year.
- (2) An applicant should have other diagnostic capabilities, on-site or through referral arrangements, with appropriate volumes including:

	Proposed Threshold
Nuclear medicine imaging services	5,600
Single photon emission computed tomography (including brain, bone, liver, gallium and thallium stress)	1,600
CT	8,000
MRI	2,400

(3) An applicant should demonstrate secondary and tertiary service capability, on-site or through referral arrangements, including cardiac surgery, cardiology, internal medicine, general surgery, hematology/oncology, neurology, pathology, thoracic surgery and psychiatry.

b. An applicant in an area with one or more PET units currently in operation or approved by the certificate of need program for operation.

Existing PET units within the area (whether basic or enhanced) should have been operating at a minimum of 1,000 PET procedures during the most recent annual period as reported to the certificate of need program according to paragraph 124.6(4)“e.”

124.6(4) *Quality and continuity.* (Iowa Code section 135.63(1)“g,” “h,” “i,” and “k”)

a. A proposed PET unit should function as a component of a comprehensive inpatient or outpatient diagnostic service. The proposed PET unit should have the following modalities (and capabilities) on-site or through referral arrangements:

- (1) CT.
- (2) MRI.
- (3) Nuclear medicine—cardiac, SPECT.
- (4) Conventional radiography.

b. A proposed PET unit should be located in a facility that has, either in-house or through referral arrangement, the resources necessary to treat most of the conditions diagnosed or confirmed by PET. The following medical specialties should be available during PET service hours on-site or by referral arrangements: cardiology, neurology, neurosurgery, oncology, and psychiatry.

c. A proposal to provide new or expanded PET must include satisfactory assurances that services will be offered in a physical environment that conforms to federal standards, manufacturer’s specifications, and licensing agencies’ requirements. The following areas are to be addressed:

- (1) Quality control and assurance of radiopharmaceutical production of generator- or cyclotron-produced agents;
- (2) Quality control and assurance of PET tomograph and associated instrumentation;
- (3) Radiation protection and shielding;
- (4) Radioactive emissions to the environment.

d. An applicant will provide evidence that the proposed PET equipment has been certified for clinical use by the U.S. Food and Drug Administration or will be operated under the approval and authority of an institutional review board whose membership is consistent with U.S. Department of Health and Human Services regulations.

e. An applicant for PET will document that the necessary qualified staff are available to operate the proposed unit. The applicant will document the PET training and experience of the staff. The following minimum staff will be available to the PET unit:

(1) One or more nuclear medicine imaging physician(s) available to the PET unit who have been licensed by the state for the handling of medical radionuclides and whose primary responsibility for at least a one-year period prior to submission of the certificate of need application has been in acquisition and interpretation of tomographic images. This individual shall have knowledge of PET through training, experience, or documented postgraduate education. The individual shall also have training with a functional PET facility.

(2) Qualified PET radiochemist or radiopharmacist personnel available to the facility during PET service hours with at least one year of training. The individual(s) will demonstrate experience in the testing of chemical, radiochemical, and radionuclidic purity of PET radiopharmaceutical syntheses.

(3) Qualified engineering and physics personnel available to the facility during PET service hours with training and experience in the operation and maintenance of the PET equipment.

(4) Qualified radiation safety personnel available to the facility at all times with training and experience in the handling of short-lived positron-emitting nuclides.

(5) Certified nuclear medicine technologists with expertise in computed tomographic nuclear medicine imaging procedures at a staffing level consistent with the proposed center's expected PET service volume.

(6) Other appropriate personnel should be available during PET service hours, which may include certified nuclear medicine technologists, computer programmers, nurses, and radiochemistry technicians.

f. An applicant will demonstrate how emergencies within the PET unit will be managed in conformity with accepted medical practice.

124.6(5) *Accessibility and acceptability.* (Iowa Code section 135.63(1) "c" and "d")

a. A PET facility should have adequate scheduled hours to avoid an excessive backlog of cases.

b. Selection of patients for clinical PET studies will guarantee equal access to all persons regardless of insurance coverage or ability to pay.

c. In addition to accepting patients from participating institutions, a facility performing clinical PET procedures should accept appropriate referrals from other local providers. These patients will be accommodated to the extent possible by extending the hours of service and by prioritizing patients according to standards of need and appropriateness rather than source of referral.

124.6(6) *Costs and financial feasibility.* (Iowa Code section 135.63(1) "e," "f," "i," and "p")

a. An applicant will identify capital and operating costs associated with a proposed PET unit, identify sources of funding to cover those costs, and demonstrate that the project is financially feasible.

b. An applicant will provide budgets for the first three years of operation, including documentation and justification of all assumptions used.

c. An applicant will document its projected average cost per procedure and charge per procedure for the first three years. Charges for PET should be reasonably related to service cost and comparable to PET charges at other facilities in the state.

d. An applicant should verify whether the service is eligible for reimbursement by public and private third-party payers.

e. An applicant should demonstrate that alternatives were considered and the proposed application is the most cost-effective and should accomplish the goals of the project.

[ARC 0320D, IAB 5/27/26, effective 7/1/26]

These rules are intended to implement Iowa Code sections 135.61 through 135.78.

[Filed ARC 0320D (Amended Notice ARC 0175D, IAB 4/1/26; Notice ARC 9796C, IAB 12/10/25),
IAB 5/27/26, effective 7/1/26]

CHAPTERS 311 to 2503
Reserved

CHAPTER 2504
RULE WAIVERS

Chapter rescission date pursuant to Iowa Code section 17A.7: 7/1/31

The Uniform Rules on Agency Procedure, 7—Chapters 2500 through 2506, are rules generally applicable to agencies pursuant to Iowa Code section 17A.24. Additions, exceptions, or amendments to the corresponding chapters are below.

[ARC 0300D, IAB 5/27/26, effective 7/1/26]

441—2504.3(17A) Evaluation.

2504.3(2) The agency will evaluate the petition in accordance with Iowa Code section 17A.9A. The agency may request additional information from the petitioner or any person as part of its evaluation of the petition.

7—paragraphs 2504.3(2) “a” and “b” are not adopted.

[ARC 0300D, IAB 5/27/26, effective 7/1/26]

[Filed Emergency ARC 0300D, IAB 5/27/26, effective 7/1/26]

CHAPTER 2505
FAIR INFORMATION PRACTICES

Chapter rescission date pursuant to Iowa Code section 17A.7: 7/1/31

The Uniform Rules on Agency Procedure, 7—Chapters 2500 through 2506, are rules generally applicable to agencies pursuant to Iowa Code section 17A.24. Additions, exceptions, or amendments to the corresponding chapters are below.

[ARC 0300D, IAB 5/27/26, effective 7/1/26]

441—2505.1(17A,22) Definitions. As used in this chapter:

“*Client*” means a person who has applied for or received services or assistance from the agency.

“*Disclosure*” means the same as defined in 45 CFR §160.103 as amended to June 25, 2024.

“*Health care operations*,” for covered entities in the agency, means the same as defined in 45 CFR §164.501 as amended to March 26, 2013.

“*Payment*,” with respect to protected health information, means the same as defined in 45 CFR §164.501 as amended to March 26, 2013. For the agency’s purposes, “payment” applies to subjects for whom health care coverage is provided under the Medicaid program or the hawki program.

“*Protected health information*” or “*PHI*” means the same as defined in 45 CFR §160.103 as amended to July 1, 2026.

“*Record*” means the whole or a part of a “public record” as defined in Iowa Code section 22.1 that is owned by or in the physical possession of the agency.

“*Subject*” means the person who is the subject of the record, whether living or deceased.

“*Treatment*” means the same as defined in 45 CFR §164.501 as amended to March 26, 2013.

“*Use*,” with respect to PHI, means the same as defined in 45 CFR §160.103 as amended to July 1, 2026.

[ARC 0300D, IAB 5/27/26, effective 7/1/26]

441—2505.5(17A,22) Requests for treatment of a record as a confidential record and its withholding from examination.

2505.5(4) The agency shall also allow individuals to request restrictions on the use or disclosure of PHI and alternative means of confidential communication, consistent with 45 CFR §164.522 as amended to July 1, 2026. The agency will maintain written procedures for processing such requests and document any granted restrictions.

[ARC 0300D, IAB 5/27/26, effective 7/1/26]

441—2505.7(17A,22) Consent to disclosure by the subject of a confidential record.

2505.7(1) The agency shall include provisions for disclosures of confidential information consistent with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and any applicable state or federal law as amended to July 1, 2026, including:

- a. Emergency exceptions;
- b. Disclosures requiring opportunity to agree or object;
- c. Disclosures when an individual is not present;
- d. Disaster relief disclosures; and
- e. Routine disclosures for:
 - (1) Internal operations;
 - (2) Contractors and agents working on behalf of the agency;
 - (3) Judicial or administrative proceedings;
 - (4) Medicaid billing;
 - (5) Child support recovery; and
 - (6) Research purposes.

2505.7(2) Additionally, the agency shall maintain written policies for general uses and disclosures of PHI for treatment, payment, and health care operations.

[ARC 0300D, IAB 5/27/26, effective 7/1/26]

441—2505.9(22,252G) Personally identifiable information. The nature and extent of personally identifiable information collected by the agency varies by the type of record. This rule describes personally identifiable information collected, maintained, and retrieved by the agency by personal identifiers in record systems and the legal authority for the collection of that information. This rule also identifies the legal authority for keeping some or all of the collected personally identifiable information confidential.

2505.9(1) Agency administrative records.

a. Personnel records. These records contain information about employees, families and dependents, and applicants for positions with the agency. Some of this information is confidential under Iowa Code section 22.7(11) and 22.7(18).

b. Fiscal records. These records contain itemized vouchers collected from individuals pursuant to Iowa Code section 8A.514. Some of this information is confidential under Iowa Code section 22.7(11) and 22.7(18).

c. Litigation files. These files or records contain information regarding litigation or anticipated litigation, which includes judicial and administrative proceedings. The records include briefs, depositions, docket sheets, documents, correspondence, attorney's notes, memoranda, research materials, witness information, investigation materials, information compiled under the direction of the attorney, and case management records. The files contain materials that are confidential as attorney work product and attorney-client communications. Some materials are confidential under other applicable provisions of law or because of a court order. Persons wishing copies of pleadings and other documents filed in litigation should obtain them from the clerk of the appropriate court that maintains the official copy. These records are confidential as outlined in Iowa Code sections 217.30, 22.7(4) and 622.10.

2505.9(2) Program records.

a. Adoption investigator certification. These records are collected pursuant to Iowa Code chapter 600.

b. Adoption program records. These records are collected pursuant to Iowa Code sections 600.8 and 600.16. These records are confidential as outlined in Iowa Code sections 600.16 and 600.24.

c. Appeals. These records are collected pursuant to Iowa Code section 217.1A. Some of these records are confidential as outlined in Iowa Code section 217.1A. Each appeal to the department will be governed by the specific state and federal laws that control it.

d. AIDS drug reimbursement program. These records are collected for purposes of implementing a federal grant program authorized by HR 1827 as amended to June 27, 1987. Certain patient records are confidential as outlined in Iowa Code section 141A.9.

e. Brain injury service program recipients. These records are collected pursuant to Iowa Code section 135.22B. These records are confidential as outlined in Iowa Code section 135.22(2).

f. Congenital and inherited disorders. These records are collected pursuant to Iowa Code chapter 136A. These records are confidential as outlined in Iowa Code section 136A.7.

g. Central registry for brain or spinal cord injuries. These records are collected pursuant to Iowa Code section 135.22. Except for statistical reports, these records are maintained as confidential pursuant to Iowa Code section 135.22.

h. Child abuse program. These records are collected pursuant to Iowa Code section 235A.14. These records are confidential as outlined in Iowa Code sections 235A.13, 235A.15, 235A.16, and 235A.17.

i. Child care assistance client records. These records are collected pursuant to Iowa Code chapter 237A. These records are confidential as outlined in Iowa Code section 237A.13.

- j.* Child care facility licensing. These records are collected pursuant to Iowa Code chapter 237A. Some of these records are confidential as outlined in Iowa Code section 237A.7.
- k.* Childhood lead poisoning prevention program. These records are collected pursuant to Iowa Code sections 135.100 through 135.105. Certain records are confidential as outlined in Iowa Code chapter 139A.
- l.* Child support recovery program. These records are collected pursuant to Iowa Code chapters 252A, 252B, 252C, 252D, 252E, 252F, 252G, 252H, 252I, 252J, and 252K and sections 144.13, 144.26, 232.147, 234.39, 595.4, 598.22B and 600.16A. These records are confidential as outlined in Iowa Code sections 252B.9 and 252G.5; 42 U.S.C. §654(26) as amended to July 1, 2026; 42 U.S.C. §654a(d) as amended to July 1, 2026; and 45 CFR §303.21 and §307.13 both as amended to July 1, 2026.
- m.* Chronic disease prevention and management programs. These records are collected pursuant to Iowa Code section 135.11(1). Certain medical information in these records is confidential as outlined in Iowa Code section 22.7(2).
- n.* Collection service center payment. These records are collected pursuant to Iowa Code sections 252B.9, 252B.13A and 252B.16. These records are confidential as outlined in Iowa Code section 252B.9(2) and 42 U.S.C. §654a(d) and 45 CFR §307.13 both as amended to July 1, 2026.
- o.* Criminal and juvenile justice information. These records are collected pursuant to Iowa Code sections 216A.136 and 216A.138 and through interagency agreements.
- p.* Dental health program. These records are collected pursuant to Iowa Code section 135.11(14). Certain medical information in these records is confidential as outlined in Iowa Code section 22.7(2).
- q.* Dependent adult abuse program. These records are collected pursuant to Iowa Code section 235B.1. These records are confidential as outlined in Iowa Code section 235B.1.
- r.* Domestic abuse death review. These records are collected pursuant to Iowa Code section 135.110. These records are confidential as outlined in Iowa Code section 135.111.
- s.* Emergency medical services. These records are collected pursuant to Iowa Code chapter 147A.
- t.* Environmental health program. These records are collected pursuant to Iowa Code section 135.11(1); PL 96-510, Section 104(d)(1); 40 CFR 763 effective June 28, 1983; and 40 CFR 761 effective May 31, 1979, and both as amended to July 1, 2026, dealing with asbestos, PCB and other environmental health factors. Certain medical information in the work-related disease program file may be confidential as outlined in Iowa Code section 22.7(2). Certain asbestos and PCB inspection records are collected under contract with the federal Environmental Protection Agency, and requests for such records will be referred to that agency.
- u.* Family investment program client records. These records are collected pursuant to Iowa Code section 234.6. These records are confidential as outlined in Iowa Code section 217.30 and 42 U.S.C. §602(a)(1) and §1306a as amended to July 1, 2026.
- v.* Food assistance client files. These records are collected pursuant to Iowa Code section 234.6. These records are confidential as outlined in Iowa Code section 217.30; 7 U.S.C. §2020(e)(8) as amended to July 1, 2026; and 7 CFR §272.1(c) and (d) as amended to June 23, 2000.
- w.* Foster care client/service files. These records are collected pursuant to Iowa Code sections 237.3 through 237.5. These records are confidential as outlined in Iowa Code section 237.9.
- x.* Foster care facility licensing. These records are collected pursuant to Iowa Code chapter 237. Some of these records are confidential as outlined in Iowa Code section 237.9.
- y.* Foster care review board files. These records are collected pursuant to Iowa Code section 237.17. Some of these records are confidential as outlined in Iowa Code section 237.21.
- z.* Hawki client files. These records are collected pursuant to Iowa Code section 514I.4. These records are confidential as outlined in Iowa Code section 514I.4 and 42 CFR §457.1110 as amended to January 1, 2001.

aa. Human rights advocacy files. These records are collected pursuant to Iowa Code chapter 216A; the Omnibus Budget Reconciliation Act, PL 97-35 as amended to July 1, 2026; Juvenile Justice and Delinquency Prevention Act, PL 93-415 as amended to July 1, 2026; and the Victims Compensation and Assistance Act, PL 98-473 as amended to July 1, 2026. These records are confidential as outlined in Iowa Code section 22.7(18).

ab. Long-term and managed care ombudsman complaints. These records are collected pursuant to Iowa Code sections 135C.37 and 231.42. These records are confidential as outlined in Iowa Code sections 135C.37 and 231.42.

ac. Maternal and child health program. These records are collected pursuant to Iowa Code section 135.11(13). Records that contain medical information are confidential pursuant to Iowa Code section 22.7(2).

ad. Medicaid clients. These records are collected pursuant to Iowa Code section 249A.4. These records are confidential as outlined in Iowa Code section 217.30; 42 U.S.C. §1396a(7) as amended to July 1, 2026; and 42 CFR §431.300 through 307 as amended to November 13, 1996.

ae. Medicaid provider information. These records are collected pursuant to Iowa Code section 249A.4. Some of these records are confidential as outlined in Iowa Code section 217.30; 42 U.S.C. §1396a(7) as amended to July 1, 2026; and 42 CFR §431.300 through 307 as amended to November 13, 1996.

af. Newborn and infant hearing screening program. These records are collected pursuant to Iowa Code section 135.131. Information that identifies an individual patient is confidential as outlined in Iowa Code section 135.131.

ag. Nutrition and WIC (Special Supplemental Nutrition Program for Women, Infants and Children) program. These records are collected pursuant to Iowa Code section 135.11(1) and Chapter 17 of the federal Child Nutrition Act of 1966 as amended to January 5, 2023. These records are confidential as outlined in 7 CFR 246 as amended to July 1, 2026, and Iowa Code section 22.7(2).

ah. Radiological health program. These records are collected pursuant to Iowa Code chapters 136B and 136C. Certain records are confidential as outlined in rule 641—39.6(136C).

ai. Refugee health program. These records are collected pursuant to Iowa Code section 135.11(1) and Section 412(c)(3) of the federal Immigration and Naturalization Act as amended to July 1, 2026. Records that contain medical information are confidential pursuant to Iowa Code section 22.7(2).

aj. Refugee resettlement client records. These records are collected pursuant to Iowa Code section 217.1A. These records are confidential as outlined in Iowa Code section 217.30 and 45 CFR §400.27 as amended to March 22, 2000.

ak. Reportable diseases and other diseases and health conditions, including lead and other heavy metal poisonings. These records are collected pursuant to Iowa Code chapter 139A. Except for statistical reports, these records are confidential as required by Iowa Code chapter 139A.

al. Reportable sexually transmitted diseases or infections. These records are collected pursuant to Iowa Code chapter 139A. Except for statistical reports, these records are confidential as required by Iowa Code chapter 139A.

am. State institution resident records. These records are collected pursuant to Iowa Code section 218.1. These records are confidential as outlined in Iowa Code sections 218.22, 229.24 and 229.25.

an. State supplementary assistance clients. These records are collected pursuant to Iowa Code chapter 249. Some of these records are confidential as outlined in Iowa Code section 217.30.

ao. Substance use client records. These records are collected pursuant to Iowa Code chapters 125 and 218 and sections 234.6 and 249A.4. These records are confidential as outlined in Iowa Code section 125.93; 42 U.S.C. §29dd-2 and ee.3 as amended to January 1, 2024; 42 CFR Part 2 as amended to April 16, 2024; and 38 U.S.C. §4132 as amended to July 1, 2026.

ap. Substance use program licensing complaints. These records are collected pursuant to Iowa Code chapter 125. Certain information in these records may be confidential as outlined in Iowa Code section 22.7(2) and 22.7(18).

aq. Title IV-E foster care and adoption assistance client files. These records are collected pursuant to Iowa Code sections 217.1A and 600.17 through 600.22. These records are confidential as outlined in Iowa Code section 217.30; 42 U.S.C. §671(a)(8) as amended to July 1, 2026; and 45 CFR §1355.30(1) as amended to January 20, 2016.

ar. Veterinary public health. These records are collected pursuant to Iowa Code chapter 139A. Certain medical information in these records may be confidential as outlined in Iowa Code chapter 139A.

as. Vital records. These records are collected pursuant to Iowa Code chapter 144, including records of births, deaths, fetal deaths, adoptions, marriages, divorces, annulments and related data and correspondence. These records are confidential as outlined in Iowa Code section 144.43.

2505.9(3) Other restricted data contained in agency client records include the following.

a. *Department of revenue information.* These records are collected pursuant to Iowa Code sections 252B.5 and 252B.9. These records are confidential as outlined in Iowa Code sections 421.17 and 422.20(1).

b. *Department of workforce development information.* These records are collected pursuant to Iowa Code chapters 239B and 249A and section 252B.9. These records are confidential as outlined in Iowa Code section 217.30 and 42 U.S.C. §503(d) and (e) as amended to July 1, 2026.

c. *Income and eligibility verification system.* These records are collected pursuant to Iowa Code chapters 239B and 249A and sections 217.1A and 234.6. These records are confidential as outlined in Iowa Code section 217.30 and 42 U.S.C. §1230b-7 as amended to July 1, 2026.

d. *Department of public safety information.* These records are collected pursuant to Iowa Code sections 237.8, 237A.5 and 252B.9. These records are confidential as outlined in Iowa Code sections 692.2, 692.3, 692.8 and 692.18.

e. *Federal tax return information.* These records are collected pursuant to Iowa Code chapters 239B, 249A and 252B and sections 217.1A and 234.6. These records are confidential as outlined in Iowa Code section 422.20(2) and 26 U.S.C. §6103 as amended to July 1, 2026.

f. *Juvenile court information.* These records are collected pursuant to Iowa Code chapter 232 and section 234.6. These records are confidential as outlined in Iowa Code sections 232.48, 232.97 and 232.147 through 232.151.

g. *Peer review organization.* These records are collected pursuant to Iowa Code section 249A.4. These records are confidential as outlined in Iowa Code section 217.30 and 42 U.S.C. §1320c-9 as amended to July 1, 2026.

h. *United States Department of Health and Human Services information.* These records are collected pursuant to Iowa Code chapters 239B, 249, 249A and 252B and sections 217.1A and 234.6. These records are confidential as outlined in Iowa Code section 217.30 and 42 CFR Part 401.134(c) as amended to October 1, 2002.

[ARC 0300D, IAB 5/27/26, effective 7/1/26]

These rules are intended to implement Iowa Code chapters 17A, 22, 135, 217, 228, and 252G and the Health Insurance Portability and Accountability Act of 1996 as amended to July 1, 2026.

[Filed Emergency ARC 0300D, IAB 5/27/26, effective 7/1/26]

CHAPTER 2506 CONTESTED CASES

Chapter rescission date pursuant to Iowa Code section 17A.7: 7/1/31

The Uniform Rules on Agency Procedure, 7—Chapters 2500 through 2506, are rules generally applicable to agencies pursuant to Iowa Code section 17A.24. Additions, exceptions, or amendments to the corresponding chapters are below.

[ARC 0300D, IAB 5/27/26, effective 7/1/26]

441—2506.2(17A) Definitions.

“*Enrollee*” means any applicant for or recipient of benefits or services provided by a program administered by the agency or on the agency’s behalf.

“*Good cause*,” for purposes of this chapter, has the same meaning as “good cause” for setting aside a default judgment under Iowa Rule of Civil Procedure 1.977.

“*Household*” means the same as defined in 7 CFR §273.1 as amended to July 1, 2026.

“*Intentional program violation*” means the same as established in 7 CFR §273.16 as amended to August 1, 2024.

“*Medicaid*” means Iowa’s medical assistance program administered under Iowa Code chapter 249A.

“*Party-in-interest*” refers to the party, including enrollees, whose rights or obligations are the subject of a contested case hearing under this chapter. Parties-in-interest may or may not be the appellant.

[ARC 0300D, IAB 5/27/26, effective 7/1/26]

441—2506.3(17A) Time obligations.

2506.3(1) In computing any time period specified in this chapter, the period:

- a. Excludes the day of the event that triggers the period;
- b. Includes every day of the time period (including Saturdays, Sundays, and holidays on which the agency is closed); and
- c. Includes the last day of the period, but if the last day is a Saturday, Sunday, or a legal holiday, the period continues to run until the end of the next day that is not a Saturday, Sunday, or legal holiday.

[ARC 0300D, IAB 5/27/26, effective 7/1/26]

441—2506.4(17A) Electronic requests for contested case proceeding.

2506.4(3) *When a contested case hearing will be granted.* A person will be granted a contested case hearing if the party-in-interest fulfills all the following requirements:

- a. The party-in-interest is entitled to a contested case hearing;
- b. The party-in-interest has an ongoing, specific and personal interest in the outcome of the contested case hearing; and
- c. The party-in-interest meets all the other requirements contained in these rules.

2506.4(4) *When a contested case hearing will not be granted.* A contested case hearing will not be granted when one of the following issues is appealed:

- a. Patient treatment interventions outlined in the patient handbook of the civil commitment unit for sexual offenders as amended to July 1, 2026.
- b. Children have been removed from or placed in a specific foster care setting or preadoptive placement.
- c. A final decision from a previous hearing with a presiding officer has been implemented.
- d. A request for a waiver of administrative rule has been denied.

2506.4(5) *Exhaustion of remedies.* A person will only be granted a contested case hearing if the person has exhausted all other appeal remedies available. A person should refer to program-specific provisions for the appropriate procedures applicable to the specific program.

2506.4(6) *Exception for requesting a contested case proceeding hearing for Supplemental Nutrition Assistance Program (SNAP) and Medicaid appeals.* A person entitled to a contested case or hearing for Medicaid and SNAP appeals may request it:

- a.* By submitting an electronic request through the agency's website;
- b.* By telephone;
- c.* By mail;
- d.* In person; or
- e.* Through other commonly available electronic means (such as email).

2506.4(7) *Time to file appeals.* For all requests for contested case hearing, and unless federal or state law provides otherwise, the person must file the request for contested case hearing on or before the thirtieth day following the date of notice of the action being appealed. If such an appeal is made more than 30 days, but less than 90 days, after the date of notice, the director or director's designee may, at the director's or designee's sole discretion, allow a contested case hearing if the delay was for good cause, substantiated by the person.

2506.4(8) *Acceptance or denial of appeal.* The agency will determine with reasonable promptness whether the person who has filed the appeal is entitled to a contested case hearing. If a request is accepted, the agency will designate the issues. If a request is denied, the agency will provide written notice of and the reasons for the denial. On or before the thirtieth day following the denial, the person requesting the appeal may provide additional information related to the person's asserted right to a contested case hearing and request reconsideration of the denial.

2506.4(9) *Designation of issues.*

a. Initial designation. The issues initially designated by the agency will be certified to the department of inspections, appeals, and licensing (DIAL) and be identified in the notice of hearing.

b. Additional designation of issues. If any person believes additional issues should be designated, the person shall identify the additional issues within the following timelines. The presiding officer shall determine whether all issues have properly been preserved.

(1) Child abuse and dependent adult abuse registry appeals. For a child abuse and dependent adult abuse registry appeal, the person shall identify additional issues at least 30 days before the date of hearing.

(2) Appeals set on or before the fifteenth day following the notice of hearing. If the hearing is on or before the fifteenth day following the date of the notice of hearing, the person shall identify any additional issues at the hearing.

(3) All other appeals. For all other appeals not identified in this paragraph, the person shall identify the additional issues on or before the fifteenth day following the date of the notice of hearing.

2506.4(10) *Agency responsibilities on SNAP hearing requests.* Upon request, the agency will make available without charge the specific materials necessary for a household or its representative to determine whether a hearing should be requested or to prepare for a hearing. If the person making the request speaks a language other than English and the agency is required by 7 CFR §272.4(c)(3) as amended to July 1, 2026, to provide bilingual staff or interpreters who speak the appropriate language, the agency will ensure that the hearing procedures are verbally explained in that language. Upon request, the agency will also help a household with its hearing request. If a household makes an oral request for a hearing, the agency will complete the procedures necessary to start the hearing process. Households will be advised of any legal services available that can provide representation at the hearing. This rule does not preclude the provision of these services in all other appeals.

[ARC 0300D, IAB 5/27/26, effective 7/1/26]

441—2506.5(17A) Notice of hearing.

2506.5(2) *Contents.* The notice of hearing must state:

- a. The time, place, and nature of the hearing;
 - b. The legal authority and jurisdiction under which the hearing is to be held;
 - c. The particular sections of the statutes and rules involved;
 - d. The procedural rules governing conduct of the contested case proceeding;
 - e. The procedural rules governing informal settlement;
 - f. The identity of the presiding officer, if known, or, if not, a description of who will serve as presiding officer; and
 - g. The deadline to request under Iowa Code section 17A.11 and rule 441—2506.6(17A), that the presiding officer be an administrative law judge (ALJ).
- [ARC 0300D, IAB 5/27/26, effective 7/1/26]

441—2506.6(17A) Presiding officer.

2506.6(1) If an ALJ is not assigned, any party that wants an ALJ employed by DIAL to serve as the presiding officer must file a request. The deadline for that request is 20 days after service of a notice of hearing that identifies someone other than an ALJ as the presiding officer.

[ARC 0300D, IAB 5/27/26, effective 7/1/26]

441—2506.10(17A) Consolidation—severance.

2506.10(3) *Medicaid member appeals.* Notwithstanding subrule 2506.10(1), for Medicaid member appeals, the agency and the presiding officer acting on behalf of the agency:

- a. May respond to a series of individual requests for hearing by conducting a single group hearing;
- b. May consolidate hearings only in cases in which the sole issue involved is one of federal or state law or policy;
- c. Must follow the policies of 42 CFR, Chapter IV, Subchapter C, Part 431, Subpart E, as amended to July 1, 2026;
- d. Must permit each person to present the individual's own case or be represented by the individual's authorized representative.

2506.10(4) *SNAP appeals.* The agency may respond to a series of individual requests for hearings by conducting a single group hearing. The agency may consolidate only cases where individual issues of fact are not disputed and where related issues of state or federal law, regulation, or policy are the sole issues being raised. In all group hearings, the regulations governing individual hearings must be followed. Each individual household shall be permitted to present its own case or have its case presented by a representative.

[ARC 0300D, IAB 5/27/26, effective 7/1/26]

441—2506.11(17A) Pleadings. This rule is not adopted.

[ARC 0300D, IAB 5/27/26, effective 7/1/26]

441—2506.12(17A) Electronic service and filing of pleadings and other papers.

2506.12(1) *Filing and service electronically.* Except as provided in subrule 2506.4(6), every pleading, motion, document, or other paper that is filed or served shall be executed electronically whenever possible. Filing or service by a nonelectronic method can only be upon a showing to the presiding officer of undue hardship to use electronic mail.

[ARC 0300D, IAB 5/27/26, effective 7/1/26]

441—2506.18(17A) Withdrawals.

2506.18(1) *Medicaid appeal withdrawals.* For Medicaid member appeals, the agency must record the individual's statement and telephonic signature for telephonic hearing withdrawals. For telephonic, online and other electronic withdrawals, the agency must send the affected person written confirmation, via regular mail or electronic notification in accordance with the individual's election.

2506.18(2) *SNAP appeal withdrawals.* For oral withdrawal of SNAP appeals, the agency must provide a written notice to the household within ten days of the household's request confirming the

withdrawal request and providing the household with an opportunity to request a hearing. The written notice must advise the household it has ten days from the date it receives the notice to advise the agency of its desire to request, or reinstate, the hearing. If the household timely advises the agency that it wishes to reinstate the fair hearing, the agency must provide the household with a fair hearing, within the time frames specified in 7 CFR §273.15(c) as amended to July 1, 2026, and beginning the date the household advises the agency that it wishes to reinstate its request. The agency must reinstate a fair hearing as requested from a household at least once. The agency must not deny a household's request for a fair hearing if the household is aggrieved by an agency action that differs from the reinstated action.

[ARC 0300D, IAB 5/27/26, effective 7/1/26]

441—2506.20(17A) Hearing procedures.

2506.20(3) Representation. Parties have the right to participate or to be represented in all hearings or prehearing conferences related to their case. Partnerships, corporations, limited-liability companies, and associations may be represented by any member, officer, director, or duly authorized agent. The agency may be represented by agency employees or employees of an agency contractor. Any party may be represented by an attorney, an authorized representative appointed pursuant to rule 441—76.9(249A), an authorized representative appointed pursuant to subrule 2506.20(8), or another person authorized by law. An attorney admitted pro hoc vice in accordance with Iowa Court Rules to practice in an agency administrative action in accordance with Iowa Court Rule 31.14 is obligated to have an in-state attorney present at every interaction with the presiding officer.

2506.20(8) Authorized representatives.

a. Regulations. The provisions of this subrule only apply to the extent the standards expressed in this subrule are not in conflict with other state or federal law.

b. Designation of authority. Legally recognized delegations of authority, such as guardianships, applicable designations of power of attorney, or similar designations, shall be sufficient for a delegate to serve as authorized representative under this chapter. A person who is not designated a legally recognized delegation of authority but who otherwise seeks to act as an authorized representative for a person in an appeal under this chapter shall provide a written, signed designation of authority to the agency with the request for appeal. The designation must provide the scope of the representation, applicable waivers for the release of confidential information, and any temporal or other limitations on the scope of representation. An authorized representative of a party-in-interest only represents the party-in-interest and has no independent right to appeal by virtue of the authorized representative's representation.

c. Written designation. For a person other than an attorney seeking to act as an authorized representative of a party-in-interest in a Medicaid managed care appeal, the authorized representative's written designation of authority pursuant to paragraph 2506.20(8) "b" shall be on an authorized representative form prescribed by the agency. This form is required for all managed care appeals, including those handled through the expedited appeals process. Failure to provide the form or legal documentation may result in denial of the appeal request.

2506.20(9) Appearance by attorney. Legal counsel appearing on behalf of any person in a proceeding under this chapter shall enter an appropriate written appearance.

2506.20(10) Closed to public. Contested case hearings are closed to the public, and unless otherwise provided by state or federal law, only the parties, their representatives, permissible intervenors, and witnesses may be present for a contested case hearing in the absence of mutual agreement of the parties.

[ARC 0300D, IAB 5/27/26, effective 7/1/26]

441—2506.27(17A) Appeals and review.

2506.27(1) Appeal by party.

a. Unless otherwise prohibited by law, any adversely affected party may appeal a proposed decision to the agency within 30 days after the decision is issued.

b. A managed care organization (MCO) appealing a proposed decision reversing an adverse benefit determination shall request the director's review within 72 hours from the date it received notice of the proposed decision.

c. In Medicaid and SNAP appeals, an appeal of a proposed decision to the agency shall be made within 14 days after the date the decision is issued.

d. In appeals from a child abuse assessment under Iowa Code section 235A.19, an appeal of a proposed decision to the agency shall be made within ten days after the date the decision is issued.

e. In WIC appeals, an appeal of a proposed decision to the agency shall be made within ten days after the date the decision is issued.

2506.27(2) Review. Unless otherwise prohibited by law, the agency may initiate review of a proposed decision on its own motion at any time within 30 days following the issuance of such a decision.

2506.27(7) Limited record. The director's review on appeal shall be limited to the issues and record before the contested case hearing presiding officer.

[ARC 0300D, IAB 5/27/26, effective 7/1/26]

441—2506.32(17A) Timelines for contested case hearings.

2506.32(1) Medical assistance. In cases involving the determination of medical assistance, the contested case hearing shall be held within a time frame such that the final administrative action is timely pursuant to 42 CFR §431.244(f) as amended to December 8, 2021.

2506.32(2) Community spouse resource allowance. In cases involving the determination of the community spouse resource allowance, the hearing shall be held within 30 days of the date of the appeal request.

2506.32(3) SNAP. In cases involving SNAP, the contested case hearing shall be held within a time frame such that the final administrative action is timely pursuant to 7 CFR §273.15(c) as amended to July 1, 2026.

2506.32(4) WIC. In cases involving WIC, the hearing shall be held within three weeks from the date the request for hearing was received.

[ARC 0300D, IAB 5/27/26, effective 7/1/26]

441—2506.33(17A) Medical assistance expedited review.

2506.33(1) Expedited review criteria. An appellant to a medical assistance appeal may, at any time, file with the agency a request for expedited review of the appeal. Expedited review shall be granted pursuant to 42 CFR §438.410 as amended to August 1, 2024, for an MCO appeal or 42 CFR §431.224 as amended to August 1, 2024, for a non-MCO appeal.

2506.33(2) Managed care expedited proceedings.

a. If the appellant is granted an expedited review, all subsequent proceedings shall also be expedited without an additional request if the appeal request indicates that the MCO appeal was expedited and provides the basis for expedited relief.

b. When review is expedited pursuant to this rule, the presiding officer shall issue a proposed decision as expeditiously as the enrollee's health condition requires but no later than three working days after the agency receives from the MCO the case file and information for any appeal of a denial of a service that, as indicated by the MCO:

(1) Meets the criteria for expedited resolution but was not resolved within the time frame for expedited resolution; or

(2) Was resolved within the time frame for expedited resolution but reached a decision wholly or partially adverse to the enrollee.

2506.33(3) Medicaid eligibility or preadmission and annual resident review expedited proceedings. For expedited appeals related to Medicaid eligibility or preadmission and annual resident review requirements, the presiding officer shall issue a proposed decision as expeditiously as possible but no later than seven working days after the agency receives a request for an expedited fair hearing.

2506.33(4) *Medicaid-covered benefits or services expedited proceedings.* For expedited appeals related to Medicaid-covered benefits or services, the presiding officer shall issue a proposed decision as expeditiously as possible but no later than provided in paragraph 2506.33(2) “b.”

2506.33(5) *Final decision for expedited proceeding.* The agency will issue its final decision in accordance with this rule, except as provided by subrule 2506.33(2).

2506.33(6) *Notification if expedited relief is granted or denied.* The agency will notify the appellant as expeditiously as possible whether the request for expedited relief is granted or denied. Such notice will be provided orally or through electronic means to the extent consistent with federal and state law. If oral notice is provided, the agency will follow up with written notice, which may be through electronic means to the extent consistent with federal and state law.

[ARC 0300D, IAB 5/27/26, effective 7/1/26]

441—2506.34(17A) SNAP administrative disqualification hearings. An intentional program violation is determined through a SNAP administrative disqualification hearing; through a court conviction; or through individual signs and returns a form prescribed by the agency, which may result in a period of ineligibility for the program, a claim for overpayment of benefits, or both in accordance with the procedures outlined in this rule and in 7 CFR §273.16(e) and (f) as amended to December 8, 2021.

2506.34(1) When a case is referred for an administrative disqualification hearing, the agency will mail written notification to the individual that the individual can waive the right to an administrative disqualification hearing by signing and returning a waiver of right to an administrative disqualification hearing.

2506.34(2) By signing a waiver of right to an administrative disqualification hearing, the individual:

- a. Waives the right to an administrative disqualification hearing;
- b. Consents to the SNAP disqualification period designated in the waiver of right to an administrative disqualification hearing and a reduction of benefits for the period of disqualification; and
- c. Acknowledges that remaining household members, if any, may be held responsible for repayment of the resulting claim.

2506.34(3) An administrative disqualification hearing will be scheduled if the individual does not sign and mail or fax the waiver of right to an administrative disqualification hearing to the agency within ten days of receipt of the written notification stating the individual can waive the right to an administrative disqualification hearing. The date on which the written notification is received is considered to be five days after the date on the notification unless the individual shows the notification was not received within the five-day period.

2506.34(4) An individual who waives the right to an administrative disqualification hearing will be subject to the same penalties as an individual found to have committed an intentional program violation in an administrative disqualification hearing.

[ARC 0300D, IAB 5/27/26, effective 7/1/26]

441—2506.35(17A) Continuation and reinstatement of benefits.

2506.35(1) *Programs for which no federal or state law applies.* For all assistance programs for which there is no contravening federal or state law, benefits or services shall not be suspended, reduced, restricted, or discontinued, nor shall a license, registration, certification, approval, or accreditation be revoked or other adverse action taken pending a final decision when:

- a. An appeal is filed before the effective date of the intended action; or
- b. The appellant requests a hearing within ten days of receipt of a notice to suspend, reduce, restrict, or discontinue benefits or services. The date on which the notice is received is considered to be five days after the date on the notice unless the appellant shows the notice was not received within the five-day period.

2506.35(2) *Sole issue is state or federal law or policy.* Benefits or services continued pursuant to subrule 2506.35(1) may be suspended, reduced, restricted, or discontinued if the presiding officer determines at the contested case hearing that the sole issue is one of state or federal law or policy and the agency has notified the enrollee in writing that services are to be suspended, reduced, restricted, or discontinued pending the proposed decision.

2506.35(3) *Recoup cost of services or benefits.* The agency or MCO may recoup the cost of benefits or services provided pursuant to this chapter and 7—Chapter 2506 if the adverse action appealed from is affirmed, consistent with state and federal law.

[ARC 0300D, IAB 5/27/26, effective 7/1/26]

[Filed Emergency ARC 0300D, IAB 5/27/26, effective 7/1/26]

RACING AND GAMING COMMISSION[491]

[Prior to 11/19/86, Chs 1 to 10, see Racing Commission[693]; Renamed Racing and Gaming Division [195] under the “umbrella” of Commerce, Department of [181], 11/19/86]

[Prior to 12/17/86, Chs 20 to 25, see Revenue Department[730] Chs 91 to 96]

[Transferred from Commerce Department[181] to the Department of Inspections and Appeals “umbrella”[481] pursuant to 1987 Iowa Acts, chapter 234, section 421]

[Renamed Racing and Gaming Commission[491], 8/23/89; See 1989 Iowa Acts, ch 67 §1(2), and ch 231 §30(1), 31]

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CHAPTER 2503
DECLARATORY ORDERS—MODIFICATIONS TO UNIFORM RULES

Chapter rescission date pursuant to Iowa Code section 17A.7: 6/30/31

The Uniform Rules on Agency Procedure, 7—Chapters 2500 through 2506, are rules generally applicable to agencies pursuant to Iowa Code section 17A.24. Additions, exceptions, or amendments to the corresponding chapter are below.

[ARC 0296D, IAB 5/27/26, effective 6/30/26]

491—2503.3(17A) Intervention in declaratory order proceedings.

2503.3(3) An intervenor seeking to intervene in a declaratory order proceeding is obligated to file the petition for intervention with the commission. The petition for intervention is considered filed when received either in hard copy or by email. The commission will provide the intervenor with a file-stamped copy of the petition upon request. The commission will only accept petitions for intervention that are typewritten or legibly handwritten in ink. Intervenors are also obligated to submit the petition so that it substantially conforms with the following:

BEFORE THE IOWA RACING AND GAMING COMMISSION

Petition by [name of original petitioner] For a declaratory order regarding [applicable statutes or rules].	PETITION FOR INTERVENTION

1. Facts supporting the intervenor's qualifications for intervention.
2. The answers urged by the intervenor to the question or questions presented and a summary of the reasons urged in support of those answers.
3. Reasons for requesting intervention and disclosure of the intervenor's interest in the outcome.
4. Whether the intervenor is currently a party to any proceeding involving the questions at issue and whether, to the intervenor's knowledge, those questions have been decided by, are pending determination by, or are under investigation by any agency or court of law.
5. The names and addresses of any additional persons, or a description of any additional class of persons, known by the intervenor to be affected by or interested in the questions presented.
6. Whether the intervenor consents to be bound by the determination of the matters presented in the declaratory order proceeding.

[ARC 0296D, IAB 5/27/26, effective 6/30/26]

[Filed Emergency ARC 0296D, IAB 5/27/26, effective 6/30/26]

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CONTESTED CASES—MODIFICATIONS TO UNIFORM RULES

Chapter rescission date pursuant to Iowa Code section 17A.7: 6/30/31

The Uniform Rules on Agency Procedure, 7—Chapters 2500 through 2506, are rules generally applicable to agencies pursuant to Iowa Code section 17A.24. Additions, exceptions, or amendments to the corresponding chapter are below.

[ARC 0296D, IAB 5/27/26, effective 6/30/26]

491—2506.11(17A) Pleadings in contested cases.

2506.11(1) *Filing requirements.* Filing requirements may be imposed by rule, by the notice of hearing, or by order of the presiding officer. However, pleadings other than a notice of appeal will not be required in appeals from a licensing decision by a gaming representative, gaming board, or board of stewards.

[ARC 0296D, IAB 5/27/26, effective 6/30/26]

[Filed Emergency ARC 0296D, IAB 5/27/26, effective 6/30/26]

CHAPTER 4 EMPLOYERS

[Prior to 6/9/04, see 581—Ch 21]

Chapter rescission date pursuant to Iowa Code section 17A.7: 1/1/28

495—4.1(97B) Covered employers.

4.1(1) Definition. All public employers in the state of Iowa, its cities, counties, townships, agencies, political subdivisions, instrumentalities and public schools are required to participate in IPERS. For the purposes of these rules, the following definitions also apply:

a. “Political subdivision” means a geographic area or territorial division of the state which has responsibility for certain governmental functions. Political subdivisions are characterized by public election of officers and taxing powers. The following examples are representative: cities, municipalities, counties, townships, schools and school districts, drainage and levee districts, and utilities.

b. “Instrumentality of the state or a political subdivision” means an independent entity that is organized to carry on some specific function of government. Public instrumentalities are created by some form of governmental body, including federal and state statutes and regulations, and are characterized by being under the control of a governmental body. Such control may include final budgetary authorization, general policy development, appointment of a board by a governmental body, and allocation of funds.

c. “Public agency” means state agencies and agencies of political subdivisions. Representative examples include an executive board, commission, bureau, division, office, or department of the state or a political subdivision.

d. Effective July 1, 1994, the definition of employer includes an area agency on aging that does not offer an alternative plan to all of its employees that is qualified under the federal Internal Revenue Code.

Covered employers include, but are not limited to: the state of Iowa and its administrative agencies; counties, including their hospitals and county homes; cities, including their hospitals, park boards and commissions; recreation commissions; townships; public libraries; cemetery associations; municipal utilities including waterworks, gasworks, electric light and power; school districts including their lunch and activity programs; state colleges and universities; and state hospitals and institutions.

An entity not already reporting to IPERS which meets the conditions for becoming an IPERS-covered employer shall immediately contact IPERS to provide notice which includes the name and address of the entity and other information required by IPERS. If, after review of this information, IPERS determines that the entity should be enrolled as a covered employer, IPERS will notify the entity and provide an IPERS account number for the entity to use when submitting information. IPERS shall not be required to provide benefits otherwise available under Iowa Code chapter 97B for periods of service prior to the effective date for which IPERS actually approves the entity for coverage, unless the employer agrees to pay the full actuarial cost of providing such benefits.

An employer may request a revised beginning date for its status as a covered employer. The employer must submit acceptable proof to IPERS that its status as a covered employer began earlier than the date previously provided. In such case, the employer shall provide IPERS coverage retroactively to all employees providing services to that employer on or after the revised beginning date and shall pay all actuarial costs.

4.1(2) Name change. Any employer which has a change of name, address, title of the employer, its reporting official or any other identifying information shall immediately give notice in writing to IPERS. The notice shall provide IPERS with the following information:

- a.* Former name;
- b.* Former address;
- c.* IPERS account number;

- d. New name, address, and telephone number of the employer;
- e. Reason for the change if other than a change of reporting official; and
- f. Effective date of the change.

4.1(3) Termination. Any employer which terminates or is dissolved for any reason shall provide IPERS with the following:

- a. Complete name and address of the dissolved entity;
- b. Assigned IPERS account number;
- c. Last date on which wages were paid;
- d. Date on which the entity dissolved;
- e. Reason for the dissolution;
- f. Whether or not the entity expects to pay wages in the future;
- g. Whether the entity is being absorbed by another covered employer;
- h. Name and address of absorbing employer if applicable; and
- i. Name and address of employer that will retain the records of the dissolved entity.

4.1(4) Reports of dissolved or absorbed employers. An employer that has been dissolved or entirely absorbed by another employer is required to file a monthly report with IPERS through the effective date on which it was dissolved or absorbed. Any wages paid after this date are reported under the account number assigned to the new or successor employer, if any.

4.1(5) IPERS account number. Each employer is assigned an IPERS account number. This number should be used on all correspondence and reporting forms directed to IPERS.

4.1(6) Patient advocates. For patient advocates employed under Iowa Code section 229.19, the county or counties for which services are performed shall be treated as the covered employer(s) of such individuals, and each such employer is responsible for forwarding reports and for withholding and forwarding the applicable IPERS contributions on wages paid by each employer.

[ARC 3684C, IAB 3/14/18, effective 4/18/18]

495—4.2(97B) Records to be kept by the employer.

4.2(1) General. Each employer shall maintain records to show the information hereinafter indicated. Records shall be kept in the form and manner prescribed by IPERS. Records shall be open to inspection and may be copied by IPERS and its authorized representatives at any reasonable time.

4.2(2) Required information. Records shall show with respect to each employee:

- a. Employee's name, address, gender, and social security account number, and other demographic information that may be required;
- b. Each date the employee was paid wages or other wage equivalent (e.g., room, board);
- c. Total amount of wages paid on each date including noncash wage equivalents;
- d. Total amount of wages including wage equivalents on which IPERS contributions are payable;
- e. Amount withheld from wages or wage equivalents for the employee's share of IPERS contributions; and
- f. Effective January 1, 1995, records will show, with respect to each employee, member contributions picked up by the employer.

4.2(3) Reports.

- a. Each employer shall make reports as IPERS may require and shall comply with the instructions provided by IPERS for the reports.
- b. Effective July 1, 2021, employers shall report the termination date and date of final paycheck for all terminating employees to IPERS with the final wage report for such employee. This report shall contain the employee's last-known mailing address and such other information as IPERS might require.
- c. The Iowa department of administrative services and the Iowa department of corrections shall notify IPERS prior to adding additional job classifications to the protection occupation class. The

notification shall include the effective date, names and social security numbers of the employees involved.

4.2(4) Fees. IPERS may assess to the employer a fee for administrative costs as described in subrule 4.3(6).

[ARC 8601B, IAB 3/10/10, effective 4/14/10; ARC 2981C, IAB 3/15/17, effective 4/19/17; ARC 5489C, IAB 3/10/21, effective 4/14/21]

495—4.3(97B) Wage reporting and payment of contributions by employers.

4.3(1) Payment of contributions. For wages paid on or after July 1, 2008, all covered employers are required to pay contributions on a monthly basis. Upon enrollment as an IPERS-covered employer, the employer shall receive the appropriate forms and instructions from IPERS to submit contributions. IPERS will provide monthly statements to each employer.

IPERS accepts the payment of contributions through electronic funds transfer. Payments utilizing the electronic funds transfer system shall be made according to the procedure described in subrule 4.3(3).

IPERS accepts the payment of contributions using checks and remittance advice forms. Employers filing monthly employer remittance advice forms on paper for two or more employers shall attach the checks to each remittance form. Checks shall be made payable to the Iowa Public Employees' Retirement System and mailed with the employer remittance advice form to IPERS, P.O. Box 9117, Des Moines, Iowa 50306-9117. Effective August 1, 2008, such payments and reports shall be subject to a fee as described in subrule 4.3(6).

4.3(2) Wage reports. For wages paid on or after July 1, 2008, all IPERS-covered employers are required to file wage reports on a monthly basis. IPERS will provide the forms and instructions for wage reporting to employers. Each wage report must include the required information for all employees who earned reportable wages or wage equivalents under IPERS. The reports must be received by IPERS on or before the fifteenth day of the month following the month in which the wages were paid. If the fifteenth day falls on a weekend or state-observed holiday, the wage report is due on the next regularly scheduled business day.

Effective August 1, 2008, IPERS shall accept wage reports electronically via IPERS' employer self-service Internet application or as a paper report. However, for those employers submitting reports other than via IPERS' employer self-service Internet application, IPERS shall charge a fee as described in subrule 4.3(6).

4.3(3) Deadlines for payment of contributions.

a. Contributions must be paid monthly and must be received by IPERS on or before the fifteenth day of the month following the month in which wages were paid. If the fifteenth day falls on a weekend or state-observed holiday, the contribution is due on the next regularly scheduled business day.

b. For employers paying contributions by electronic funds transfer, wage reports and contributions may be submitted at the same time.

4.3(4) Request for time extension. A request for an extension of time to file a wage report or pay a contribution may be granted by IPERS for good cause if a request is made before the due date, but no extension shall exceed 15 days beyond the due date. If an employer that has been granted an extension fails to submit the wage report or pay the contribution on or before the end of the extension period, the applicable interest and fees shall be charged and paid from the original due date as if no extension had been granted. If the fifteenth day falls on a weekend or state-observed holiday, the contribution or wage report is due on the next regularly scheduled business day.

To establish good cause for an extension of time to file a wage report or pay contributions, the employer must show that the delinquency was not due to mere negligence, carelessness or inattention. The employer must affirmatively show that it did not file the wage report or timely pay a contribution because of some occurrence beyond the control of the employer.

4.3(5) *No reportable wages.* When an employer has no reportable wages during the applicable reporting period, the wage reporting document shall be filed according to subrule 4.3(2). Even if there are no reportable wages, the employer's account is considered delinquent for the reporting period and is subject to a fee until the report is filed. However, if the employer has notified IPERS on or before the due date that there are no wages to report, IPERS will adjust the due date, and no fee will be charged.

4.3(6) *Fees for noncompliance.* IPERS is authorized to impose reasonable fees on employers that do not file wage reports through the IPERS' employer self-service Internet application as described in subrule 4.3(2), that fail to timely file accurate wage reports, or that fail to pay contributions when due pursuant to subrule 4.3(3).

For submissions filed on or after August 1, 2008, IPERS shall charge employers a processing fee of \$20 plus 25 cents per employee for late submissions and manual processing of wage reports by IPERS. Employers that are late or that do not use IPERS' employer self-service Internet application may be charged both fees. In addition, if a fee for noncompliance is not paid by the fifteenth day of the month after the fee is assessed, the fee will accrue interest daily at the interest rate provided in Iowa Code sections 97B.9 and 97B.70. No fee will be charged on late contributions received as a result of a wage adjustment, but interest on the amount due will be charged until paid in full.

If the due date for a fee falls on a weekend or state-observed holiday, the due date shall be the next regularly scheduled business day.

4.3(7) *Erroneously reported wages for employees not covered under IPERS.* Employers that erroneously report wages for employees who are not eligible for coverage under IPERS may file an IPERS wage reporting adjustment form. IPERS shall return a warrant or issue a credit for both the employer and employee contributions made in error. The employer is responsible for returning the employees' share and for filing corrected federal and state wage reporting forms. Adjustments in such cases will be reported on the employer's monthly statement. Under no circumstance shall the employer adjust these wages by underreporting wages on a future periodic wage reporting document. Wages shall never be reported as a negative amount. An employer that completes the employer portion of an employee's request for a refund on an IPERS refund application form will not be permitted to file a periodic wage reporting adjustment form for that employee for the same time period. No fee will be assessed to employers that correct information as provided under this subrule.

4.3(8) *Contributions paid on wages in excess of the annual covered wage maximum.* For wages paid on or after July 1, 2008, whenever IPERS determines that an employee's wages will exceed the annual maximum established under Section 401(a)(17)(A) and the cost-of-living adjustments to that maximum permitted under Section 401(a)(17)(B) of the Internal Revenue Code during a given month, IPERS shall notify the applicable employer and shall return the related excess contributions. IPERS will detail on the monthly report those employees for whom wages were reported in excess of the covered wage ceiling. The employer is responsible for returning the employee's share of excess contributions and making the applicable tax corrections.

4.3(9) *Termination within less than six months of the date of employment.* If an employee hired for permanent employment terminates within six months of the date of employment, the employer may file an IPERS form for reporting adjustments to receive a warrant or a credit, as elected by the employer, for both the employer's and employee's portions of the contributions. It is the responsibility of the employer to return the employee's share. "Termination within less than six months of the date of employment" means employment is terminated prior to the day before the employee's six-month anniversary date. For example, an employee hired on February 10 whose last day is August 8 would be treated as having resigned within less than six months. An employee hired on February 10 whose last day is August 9 (the day before the six-month anniversary date, August 10) would be treated as having worked six months and would be eligible for a refund.

4.3(10) *Reinstatement following an employment dispute.* Employees who are reinstated following an employment dispute may restore membership service credit as described in 495—9.5(97B).

[ARC 9397B, IAB 2/23/11, effective 3/30/11; ARC 2981C, IAB 3/15/17, effective 4/19/17; ARC 3684C, IAB 3/14/18, effective 4/18/18]

495—4.4(97B) Accrual of interest and application of employer payments. Interest or charges as provided under Iowa Code section 97B.9 shall accrue on all employer payments not received by IPERS by the due date, except that interest or charges may be waived by IPERS if the employer requests an extension of time under subrule 4.3(4) prior to the due date. Effective August 1, 2008, employers that remit late contributions shall be charged a minimum of \$20 or interest at the rate provided in Iowa Code section 97B.70, whichever is greater. No fee will be charged on late contributions received as a result of a wage adjustment, but interest on the amount due will be charged until paid in full. Payments received from employers having unpaid account balances shall first be applied to the oldest outstanding balance.

495—4.5(97B) Credit memos voided. Rescinded IAB 3/26/08, effective 4/30/08.

495—4.6(97B) Contribution rates. The following contribution rate schedule, payable on the covered wage of the member, is determined by the position or classification and the occupation class code of the member.

4.6(1) Contribution rates for regular class members.

a. The following contribution rates were established by the Iowa legislature for all regular class members for the indicated periods:

	Effective July 1, 2007	Effective July 1, 2008	Effective July 1, 2009	Effective July 1, 2010	Effective July 1, 2011
Combined rate	9.95%	10.45%	10.95%	11.45%	13.45%
Employer	6.05%	6.35%	6.65%	6.95%	8.07%
Employee	3.90%	4.10%	4.30%	4.50%	5.38%

b. Effective July 1, 2012, and every year thereafter, the contribution rates for regular members shall be publicly declared by IPERS staff no later than the preceding December as determined by the annual valuation of the preceding fiscal year. The public declaration of contribution rates will be followed by rulemaking that will include a notice and comment period and that will become effective July 1 of the next fiscal year. Contribution rates for regular members are as follows.

	Effective July 1, 2022	Effective July 1, 2023	Effective July 1, 2024	Effective July 1, 2025	Effective July 1, 2026
Combined rate	15.73%	15.73%	15.73%	15.73%	15.73%
Employer	9.44%	9.44%	9.44%	9.44%	9.44%
Employee	6.29%	6.29%	6.29%	6.29%	6.29%

4.6(2) Contribution rates for sheriffs and deputy sheriffs are as follows.

	Effective July 1, 2022	Effective July 1, 2023	Effective July 1, 2024	Effective July 1, 2025	Effective July 1, 2026
Combined rate	17.52%	17.02%	17.02%	24.18%	24.42%
Employer	8.76%	8.51%	8.51%	11.965%	12.085%
Employee	8.76%	8.51%	8.51%	12.215%	12.335%

4.6(3) Contribution rates for protection occupations are as follows.

	Effective July 1, 2022	Effective July 1, 2023	Effective July 1, 2024	Effective July 1, 2025	Effective July 1, 2026
Combined rate	15.52%	15.52%	15.52%	15.52%	15.52%
Employer	9.31%	9.31%	9.31%	9.185%	9.185%
Employee	6.21%	6.21%	6.21%	6.335%	6.335%

4.6(4) Members employed in a “protection occupation” shall include:

a. Conservation peace officers. Effective July 1, 2002, all conservation peace officers, state and county, as described in Iowa Code sections 350.5 and 456A.13.

b. Effective July 1, 1994, a marshal in a city not covered under Iowa Code chapter 400 or a firefighter or police officer of a city not participating under Iowa Code chapter 410 or 411. (See employee classifications in rule 495—5.1(97B).) Effective January 1, 1995, part-time police officers shall be included.

c. Correctional officers as provided for in Iowa Code section 97B.49B. Employees who, prior to December 22, 1989, were in a “correctional officer” position but whose position is found to no longer meet this definition on or after that date shall retain coverage, but only for as long as the employee is in that position or another “correctional officer” position that meets this definition. Movement to a position that does not meet this definition shall cancel “protection occupation” coverage.

d. Airport firefighters employed by the military division of the department of public defense (airport firefighters). Effective July 1, 2004, airport firefighters become part of and shall make the same contributions as the other members covered under Iowa Code section 97B.49B. From July 1, 1994, through June 30, 2004, airport firefighters were grouped with and made the same contributions as sheriffs and deputy sheriffs. From July 1, 1988, through June 30, 1994, airport firefighters were grouped with and made the same contributions as the other members covered under Iowa Code section 97B.49B. From July 1, 1986, through June 30, 1988, airport firefighters were a separate protection occupation group and made contributions at a rate calculated for members of that group. Prior to July 1, 1986, airport firefighters were grouped with regular members and made the same contributions as regular members.

Notwithstanding the foregoing, all airport firefighter service prior to July 1, 2004, shall be coded by IPERS as sheriff/deputy sheriff/airport firefighter service, and all airport firefighter service after June 30, 2004, shall be coded by IPERS as protection occupation service. This coding, however, shall not supersede provisions of this title that require members to make contributions at higher rates in order to receive certain benefits, such as in the hybrid formula pursuant to 495—12.4(97B).

e. Airport safety officers employed under Iowa Code chapter 400 by an airport commission in a city with a population of 100,000 or more, and employees covered by the Iowa Code chapter 8A merit system whose primary duties are providing airport security and who carry or are licensed to carry firearms while performing those duties.

f. Effective July 1, 1990, an employee of the state department of transportation who is designated as a “peace officer” by resolution under Iowa Code section 321.477.

g. Effective July 1, 1992, a fire prevention inspector peace officer employed by the department of public safety. Effective July 1, 1994, a fire prevention inspector peace officer employed before that date who does not elect coverage under Iowa Code chapter 97A in lieu of IPERS.

h. Effective July 1, 1994, through June 30, 1998, a parole officer III with a judicial district department of correctional services.

i. Effective July 1, 1994, through June 30, 1998, a probation officer III with a judicial district department of correctional services.

j. Effective July 1, 2008, county jailers and detention officers working as jailers.

k. Effective July 1, 2008, National Guard installation security officers.

l. Effective July 1, 2008, emergency medical care providers.

m. Effective July 1, 2008, special investigators who are employed by county attorneys.

n. Effective July 1, 2014, an employee of the insurance division of the department of commerce who as a condition of employment is required to be certified by the Iowa law enforcement academy and who is required to perform the duties of a peace officer as provided in Iowa Code section 507E.8.

o. Effective July 1, 2014, an employee of a judicial district department of correctional services whose condition of employment requires the employee to be certified by the Iowa law enforcement academy and who is required to perform the duties of a parole officer as provided in Iowa Code section 906.2.

p. Effective July 1, 2016, a peace officer employed by an institution under the control of the state board of regents whose position requires law enforcement certification pursuant to Iowa Code section 262.13.

q. Effective July 1, 2016, a person employed by the department of human services as a psychiatric security specialist at a civil commitment unit for sexually violent offenders facility.

4.6(5) Service reclassification.

a. Prior to July 1, 2006, except as otherwise indicated in the implementing legislation or these rules, for a member whose prior regular service position is reclassified by the legislature as a special service position, all prior service by the member in such regular service position shall be coded by IPERS staff as special service if certified by the employer as constituting special service under current law. No additional contributions shall be required by regular service reclassified as special service under this paragraph.

b. Effective July 1, 2006, for a member whose prior regular service position is reclassified by the legislature as a special service position, all prior service by the member in such regular service position shall continue to be coded by IPERS staff as regular service unless the legislature specifically provides in its legislation for payment of the related actuarial costs of such reclassified service as required under Iowa Code section 97B.65.

4.6(6) Effective July 1, 2006, in the determination of a sheriff's or deputy sheriff's eligibility for benefits and the amount of such benefits under Iowa Code section 97B.49C, all protection occupation service credits for that member shall count toward the total years of eligible service as a sheriff or deputy sheriff. However, this subrule shall not be construed to alter the statutory requirement that a sheriff or deputy sheriff must be employed as a sheriff or deputy sheriff at termination of covered employment in order to qualify for benefits under Iowa Code section 97B.49C.

4.6(7) Pretax.

a. Effective January 1, 1995, employers must pay member contributions on a pretax basis for federal income tax purposes only. Such contributions are considered employer contributions for federal income tax purposes and employee contributions for all other purposes. Employers must reduce the member's salary reportable for federal income tax purposes by the amount of the member's contribution.

b. Salaries reportable for purposes other than federal income tax will not be reduced, including for IPERS, FICA, and, through December 31, 1998, state income tax purposes.

c. Effective January 1, 1999, employers must pay member contributions on a pretax basis for both federal and state income tax purposes.

[ARC 7591B, IAB 2/25/09, effective 7/1/09; ARC 7759B, IAB 5/6/09, effective 4/17/09; ARC 7916B, IAB 7/1/09, effective 8/5/09; ARC 8601B, IAB 3/10/10, effective 4/14/10; ARC 9397B, IAB 2/23/11, effective 3/30/11; ARC 0017C, IAB 2/22/12, effective 3/28/12; ARC 0662C, IAB 4/3/13, effective 5/8/13; ARC 1348C, IAB 2/19/14, effective 3/26/14; ARC 1887C, IAB 2/18/15, effective 3/25/15; ARC 2402C, IAB 2/17/16, effective 3/23/16; ARC 2981C, IAB 3/15/17, effective 4/19/17; ARC 3684C, IAB 3/14/18, effective 4/18/18; ARC 4337C, IAB 3/13/19, effective 4/17/19; ARC 5027C, IAB 4/8/20, effective 5/13/20; ARC 5489C, IAB 3/10/21, effective 4/14/21; ARC 6215C, IAB 2/23/22, effective 3/30/22; ARC 6949C, IAB 3/8/23, effective 4/12/23; ARC 7811C, IAB 4/17/24, effective 5/22/24; ARC 9287C, IAB 5/14/25, effective 6/18/25; ARC 9417C, IAB 7/23/25, effective 6/30/25; ARC 0323D, IAB 5/27/26, effective 7/1/26]

495—4.7(97B) Employee information to be provided by covered employers. Covered employers are required to enroll new employees prior to reporting wages for the new employees using IPERS' employer self-service Internet application. Enrollment information shall include, but is not limited to, the following: member's name, social security number, date of birth, date of hire, occupation code, gender, mailing address, and employer identification number. When an employee terminates employment with a covered employer, the employer shall provide the termination date and the date of the employee's final paycheck.

[ARC 2981C, IAB 3/15/17, effective 4/19/17]

495—4.8(97B) Additional employer contributions from employer-mandated reduction in hours or by the exercise of bumping rights to avoid a layoff. Rescinded **ARC 2981C**, IAB 3/15/17, effective 4/19/17.

These rules are intended to implement Iowa Code sections 97B.4, 97B.9, 97B.14, 97B.14A, 97B.38, 97B.49A to 97B.49I, 97B.65 and 97B.70 and 2009 Iowa Acts, chapter 170, section 51, as amended by 2010 Iowa Acts, House File 2518, sections 36 and 41.

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[Filed Emergency ARC 7759B, IAB 5/6/09, effective 4/17/09]

[Filed ARC 7916B (Notice ARC 7760B, IAB 5/6/09), IAB 7/1/09, effective 8/5/09]

[Filed ARC 8601B (Notice ARC 8477B, IAB 1/13/10), IAB 3/10/10, effective 4/14/10]

[Filed Emergency ARC 8929B, IAB 7/14/10, effective 6/21/10]

[Filed ARC 9068B (Notice ARC 8928B, IAB 7/14/10), IAB 9/8/10, effective 10/13/10]

[Filed ARC 9397B (Notice ARC 9310B, IAB 12/29/10), IAB 2/23/11, effective 3/30/11]

[Filed ARC 0017C (Notice ARC 9951B, IAB 12/28/11), IAB 2/22/12, effective 3/28/12]

[Filed ARC 0662C (Notice ARC 0598C, IAB 2/6/13), IAB 4/3/13, effective 5/8/13]

[Filed ARC 1348C (Notice ARC 1256C, IAB 12/25/13), IAB 2/19/14, effective 3/26/14]

[Filed ARC 1887C (Notice ARC 1800C, IAB 12/24/14), IAB 2/18/15, effective 3/25/15]

[Filed ARC 2402C (Notice ARC 2331C, IAB 12/23/15), IAB 2/17/16, effective 3/23/16]

[Filed ARC 2981C (Notice ARC 2892C, IAB 1/18/17), IAB 3/15/17, effective 4/19/17]

[Filed ARC 3684C (Notice ARC 3537C, IAB 1/3/18), IAB 3/14/18, effective 4/18/18]

[Filed ARC 4337C (Notice ARC 4238C, IAB 1/16/19), IAB 3/13/19, effective 4/17/19]

[Filed ARC 5027C (Notice ARC 4925C, IAB 2/12/20), IAB 4/8/20, effective 5/13/20]

[Filed ARC 5489C (Notice ARC 5359C, IAB 12/30/20), IAB 3/10/21, effective 4/14/21]

[Filed ARC 6215C (Notice ARC 6117C, IAB 12/29/21), IAB 2/23/22, effective 3/30/22]

[Filed ARC 6949C (Notice ARC 6823C, IAB 1/11/23), IAB 3/8/23, effective 4/12/23]

[Filed ARC 7811C (Notice ARC 7648C, IAB 2/21/24), IAB 4/17/24, effective 5/22/24]

[Filed ARC 9287C (Notice ARC 9046C, IAB 3/19/25), IAB 5/14/25, effective 6/18/25]

[Filed Emergency ARC 9417C, IAB 7/23/25, effective 6/30/25]

[Filed ARC 0323D (Notice ARC 0188D, IAB 4/1/26), IAB 5/27/26, effective 7/1/26]

CHAPTER 2 ORGANIZATION

[Prior to 12/17/86, Revenue Department[730]]

Chapter rescission date pursuant to Iowa Code section 17A.7: 3/26/30

701—2.1(17A) Establishment of the department. Iowa Code sections 7E.5(1)“c” and 421.2 establish a department of revenue to be administered by a director of revenue with primary responsibility for revenue collection and revenue law compliance, as well as administration of the Iowa lottery and alcoholic beverage control.

[ARC 8944C, IAB 2/19/25, effective 3/26/25]

701—2.2(17A) Mission. The mission of the department is to serve Iowans through the responsible collection and generation of revenue to support the public good.

[ARC 8944C, IAB 2/19/25, effective 3/26/25]

701—2.3(17A) Offices. The department headquarters is maintained at the seat of state government in the Hoover State Office Building, 1305 East Walnut Street, P.O. Box 10460, Des Moines, Iowa 50319. Office hours of the department are 8 a.m. to 4:30 p.m., Monday through Friday. Offices are closed on Saturdays, Sundays, and official state holidays designated in accordance with state laws.

2.3(1) Regional office of alcohol operations. The office of alcohol operations is located at 1918 S.E. Hulsizer Road, Ankeny, Iowa 50021; telephone 515.281.7400 or 1.866.469.2223.

2.3(2) Offices of lottery operations. The main office of the Iowa lottery division is located at 13001 University Avenue, Clive, Iowa 50325-8225. The lottery division has regional offices in Cedar Rapids, Mason City, and Storm Lake, which offer some of the services available at the lottery division’s main office, and a central warehouse in Ankeny. The Iowa lottery commission may be contacted through the lottery division’s main office. Prize-redemption hours at lottery division offices are 8 a.m. to 4 p.m., Monday through Friday, with lottery offices closed on weekends and official state holidays.

[ARC 8944C, IAB 2/19/25, effective 3/26/25]

701—2.4(17A) Department Internet websites.

2.4(1) Main website of the department. The department’s main Internet home page is revenue.iowa.gov.

2.4(2) Website of lottery division. The lottery division’s Internet home page is www.ialottery.com. Information regarding the lottery’s main and regional offices can be obtained on the lottery website, on point-of-sale game-play publications, and by contacting the main office of the lottery.

[ARC 8944C, IAB 2/19/25, effective 3/26/25]

701—2.5(17A) Organization of the department. The department consists of the director, the lottery division, and other such divisions as the director may from time to time establish, abolish, or consolidate.

2.5(1) The office of the director. The essential functions of the office of the director include but are not limited to:

- a. Overall management of the agency.
- b. Review of appeals.
- c. Strategic planning and coordination of the future operations and goals of the department.
- d. Provision of financial checks and balances within the department.
- e. Facilitation of a working relationship between the public sector and the private sector.

2.5(2) Divisions. For ease of administration, the director has organized the department into divisions and, in some instances, has organized those divisions into bureaus, sections, subsections, and units. Except for the lottery division, the director may from time to time establish, abolish, or

consolidate the department's administrative divisions as the director deems necessary in order to more efficiently and effectively carry out the department's responsibilities. Such divisions may include but are not limited to:

- a.* Alcohol and tax compliance.
- b.* Alcohol and tax operations.
- c.* Financial services.
- d.* Internal services.
- e.* Legal services.
- f.* Local government services.
- g.* Lottery.
- h.* Research and policy.

2.5(3) *Designee.* Unless otherwise delegated in statute, in rule, or otherwise in writing by the director, only the director, deputy director, or chief legal officer may enter into contracts or agreements on behalf of the department.

2.5(4) *Organization of the alcoholic beverages commission.* The alcoholic beverages commission consists of five commission members appointed by the governor and confirmed by the senate.

2.5(5) *Organization of the lottery commission.* The lottery commission consists of five members appointed by the governor and confirmed by the senate.

[ARC 8944C, IAB 2/19/25, effective 3/26/25; ARC 0321D, IAB 5/27/26, effective 7/1/26]

These rules are intended to implement Iowa Code sections 17A.3, 99G.5, 99G.8, 123.5, 123.6, 123.9, 123.10, 421.2, 421.9, 421.14, 421.17, 422.1 and 422.72.

[Filed ARC 8944C (Notice ARC 8355C, IAB 11/13/24), IAB 2/19/25, effective 3/26/25]

[Filed ARC 0321D (Notice ARC 0174D, IAB 4/1/26), IAB 5/27/26, effective 7/1/26]

CHAPTER 7
TAX APPEALS, TAXPAYER REPRESENTATION,
AND OTHER ADMINISTRATIVE PROCEDURES
[Prior to 12/17/86, Revenue Department[730]]

Chapter rescission date pursuant to Iowa Code section 17A.7: 3/26/30

701—7.1(421,17A) Applicability and scope of rules. These rules implement the Iowa administrative procedure Act and aid in the effective and efficient administration and enforcement of the laws of this state and other activities of the department. These rules govern the practice, procedure, and conduct of the informal proceedings, contested case proceedings, and certain other administrative procedures within the department's jurisdiction. The rules in this chapter apply to all informal proceedings, contested case proceedings, licensing proceedings pending or commenced on or after their effective date; however, 701—Chapter 6 applies to appeals and contested case proceedings for matters under Iowa Code chapters 123 and 99G. 701—Chapter 3 contains rules on rulemaking for all matters within the department's jurisdiction. 701—Chapter 4 contains rules on declaratory order for all matters within the department's jurisdiction.

This rule is intended to implement Iowa Code chapter 17A.

[ARC 8944C, IAB 2/19/25, effective 3/26/25]

701—7.2(421,17A) Definitions. Terms not defined below have the same meaning as defined in Iowa Code chapter 17A. Unless otherwise specifically stated, the terms used in these rules promulgated by the department have the meanings defined by the Act. These definitions apply to this chapter unless the text states otherwise:

“Act” means the Iowa administrative procedure Act.

“Appeal” means a dispute of a notice of assessment, refund denial, or other department action that may culminate in a contested case proceeding. *“Protest”* has the same meaning as appeal.

“Clerk” means the clerk of the legal services and appeals division or the clerk's designee.

“Department” or *“IDR”* means the Iowa department of revenue.

“Director” means the director of the department or the director's designee.

“Division of administrative hearings” means the division of the department of inspections, appeals, and licensing responsible for holding contested case proceedings pursuant to Iowa Code chapter 10A.

“Enforcement actions and appeals bureau” means the section of the legal services division of the department designated by the director to administer the informal stage of the appeals process and participate in contested case proceedings for appeals before the department.

“Entity” means any taxpayer other than an individual or sole proprietorship.

“GovConnectIowa” means the e-services portal of the department.

“Informal stage” means the procedures of the appeals process described in rule 701—7.10(17A).

“Issuance” means the date specified in the decision or order, the date of mailing of a decision, or order or date of delivery of the decision or order if service is by other means.

“Last-known address” means the last address associated with a taxpayer by tax type, as determined pursuant to rule 701—7.23(421).

“Motion” means the same as defined in Iowa Rule of Civil Procedure 1.431.

“Party” means the same as defined in Iowa Code section 17A.2(8) and includes intervenors.

“Person” means the same as defined in Iowa Code section 17A.2. *“Public or private organization of any character or any other person covered by the Act other than an agency”* as used in that definition includes estates, trusts, or fiduciary.

“Petition” means application for declaratory order; request to intervene in a declaratory order under consideration; or application for initiation of proceedings to adopt, amend or rescind a rule or document filed in licensing.

“Pleadings” means appeal, answer, reply or other similar document filed in a contested case proceeding, including contested cases involving no factual dispute.

“Presiding officer” means the person designated to preside over a proceeding involving the department. A presiding officer of a contested case involving the department will be either the director or a qualified administrative law judge appointed, pursuant to Iowa Code chapter 17A, by the division of administrative hearings established pursuant to Iowa Code section 10A.801. In cases in which the department is not a party, at the director’s discretion, the presiding officer may be the director or the director’s designee. The presiding officer of an administrative appeal is the director of the department.

“Proceeding” means informal, formal, and contested case proceedings.

“Proposed decision” means the presiding officer’s recommended findings of fact, conclusions of law, decision, and order in a contested case in which the director did not preside, as described in Iowa Code section 17A.15.

“Review unit” means the unit composed of the enforcement actions and appeals bureau of the legal services division of the department and any of the attorney general’s staff who have been assigned to review appeals filed by taxpayers.

“Taxpayer interview” means any in-person contact between an employee of the department and a taxpayer or a taxpayer’s representative that has been initiated by a department employee.

“Taxpayer’s representative” or *“taxpayer’s authorized representative”* means an individual authorized to practice before the department on behalf of a taxpayer under Iowa Code section 421.59; an individual who has been named as an authorized representative on a fiduciary return of income form filed under Iowa Code section 422.14 or a tax return filed under Iowa Code chapter 450 or 450B; or for proceedings before the department, any other individual the taxpayer designates who is named on a valid power of attorney if appearing on behalf of another.

This rule is intended to implement Iowa Code chapter 17A.

[ARC 8944C, IAB 2/19/25, effective 3/26/25; ARC 0321D, IAB 5/27/26, effective 7/1/26]

701—7.3(17A,99G,123,421-454) How to submit an appeal, petition or related documents; service. Appeals, petitions, and other documents governed by this chapter may be filed electronically, by mail, or in person, in accordance with the limits described below. The headquarters of the department in the Hoover State Office Building in Des Moines, Iowa, will generally be open between the hours of 8 a.m. and 4:30 p.m. daily, except Saturdays, Sundays, and holidays as defined in Iowa Code section 421.9A.

7.3(1) *Ways to submit an appeal, petition, or related document.* Unless otherwise specified in another rule in this chapter, a person may submit an appeal, petition, related document, or document filed during an appeal or pending petition:

a. By submitting through GovConnectIowa. GovConnectIowa is available for filing appeals, petitions for declaratory order, petitions for rulemaking, and petitions for rule waiver for all matters before the department.

b. By email to idrhearings@iowa.gov.

c. By mail to Legal Services Division, Iowa Department of Revenue, P.O. Box 14457, Des Moines, Iowa 50306-3457.

d. By hand delivery to the department’s customer service desk in the Hoover State Office Building, First Floor, 1305 East Walnut Street, Des Moines, Iowa 50319, during regular business hours.

7.3(2) *Filings with the division of administrative hearings and service upon the department during contested case proceedings.* All documents or papers required or permitted to be filed with an administrative law judge appointed by the division of administrative hearings to be a presiding officer in a contested case shall be filed in accordance with rule 481—10.12(17A). All papers or documents required or permitted by this chapter to be filed with the department or the director and served upon the opposing party or other person in a contested case shall be served by ordinary mail unless another rule specifically refers to another method.

7.3(3) *Service by the department.* All notices or documents required or permitted by this chapter to be served on parties or persons by the department or presiding officer that are not currently pending before an administrative law judge shall be served by ordinary mail unless the taxpayer has elected to receive communications exclusively through GovConnectIowa, pursuant to rule 701—8.6(421). For taxpayers registered in GovConnectIowa, posting the document in the taxpayer's GovConnectIowa account constitutes service or notice of the document. For taxpayer representatives registered in GovConnectIowa, posting the document in the taxpayer representative's GovConnectIowa account constitutes service or notice of the document. For nonregistered taxpayers or nonregistered taxpayer representatives, documents will be served by ordinary mail. When this nonregistered mailing is required, however, the department may note on the docket the parties served and the method of service instead of filing a certificate of service. With respect to any notice, correspondence, or communication served electronically, response deadlines shall be calculated from the date the taxpayer is notified electronically of the correspondence or the item is mailed, whichever is earlier.

This rule is intended to implement Iowa Code chapter 17A.

[ARC 8944C, IAB 2/19/25, effective 3/26/25; ARC 9707C, IAB 11/12/25, effective 12/17/25; ARC 0321D, IAB 5/27/26, effective 7/1/26]

701—7.4(17A) Time requirements for filings.

7.4(1) *Computing time.* Time shall be computed in accordance with Iowa Code section 421.9A. For electronic submissions, in addition to the requirements described in Iowa Code section 421.9A, local time for the state of Iowa applies. In computing time in accordance with Iowa Code section 421.9A, the first day shall be excluded and the last included.

7.4(2) *Date of filing.* The date of filing for appeal requests, petitions, or other related documents shall be:

- a. If sent electronically either through GovConnectIowa or as described on the department's website, determined by the date on which the electronic submission was completed.
- b. If sent by regular mail, the date postmarked on the envelope sent to the department's principal office or, if the postmark is not available, the date the appeal is stamped as received by the department.
- c. If hand delivered, the date the appeal is stamped as received by the department.

This rule is intended to implement Iowa Code chapter 17A.

[ARC 8944C, IAB 2/19/25, effective 3/26/25]

701—7.5(17A) Form and style of documents.

7.5(1) *Requirements applicable to all filings under this chapter.*

a. *Signatures.* Signatures must meet the requirements of 701—subrule 8.2(6). The signature shall constitute a certification that the signer has read the document; that, under penalty of perjury, the signer declares that to the best of the signer's knowledge and belief, the information contained in the document is true, correct, and complete; and that no statement contained in the document is misleading.

b. *Citations.* Citations may be italicized or underlined.

7.5(2) *Paper.* Any paper documents that are allowed or required to be submitted by this chapter must:

- a. Be clear and legible.
- b. Be on white paper.
- c. Be on the applicable department appeal, application for reinstatement, or petition form available on the department's forms website revenue.iowa.gov/forms under the category "Applications and Other" or, if not on the department's form, include a proper caption on the first page.
- d. Include a signature.
- e. Include copies as herein provided or as specified in other applicable rules.

7.5(3) *Email.* Any documents allowed or required to be filed by email under this chapter must be:

a. A document in PDF, Microsoft Word, Microsoft Excel, or image format that complies with subrules 7.5(1) and 7.5(2), or

b. The body of an email that meets all of the requirements of subrules 7.5(1) and 7.5(2).

7.5(4) GovConnectIowa. Any documents allowed or required to be filed through GovConnectIowa under this chapter must be:

a. A document in PDF, Microsoft Word, Microsoft Excel, or image format that complies with subrules 7.5(1) and 7.5(2) that is properly uploaded and properly submitted through GovConnectIowa.

b. Completed and submitted on the applicable GovConnectIowa form.

This rule is intended to implement Iowa Code chapters 17A and 554D and sections 421.17 and 421.27A.

[ARC 8944C, IAB 2/19/25, effective 3/26/25]

701—7.6(17A) Docket. Every matter coming within the purview of this chapter is assigned a docket number that is the official identification number of the matter for the purposes of identification. The parties will be notified of the docket number. The number will be placed by the parties on all documents thereafter filed in the proceeding. After the transfer of a case to the division of administrative hearings for contested case proceedings, that division may assign another docket number to the case and, in that event, both docket numbers will be placed by the parties on all documents thereafter filed in the proceeding.

This rule is intended to implement Iowa Code chapter 17A.

[ARC 8944C, IAB 2/19/25, effective 3/26/25]

701—7.7(17A) Identifying details, requests for redaction.

7.7(1) Information redacted by the department, subject to certain exceptions. Prior to being made available for public inspection, the department will redact from an appeal or contested case the information required by Iowa Code sections 422.20(5) and 422.72(8). “Make available for public inspection” means disclosure to the public by the department pursuant to Iowa Code section 17A.3 or chapter 22.

7.7(2) Process for requesting redaction of other details from a pleading, exhibit, attachment, motion, or written evidence. If a taxpayer desires information contained in a record, other than the information described in Iowa Code sections 422.20(5) “a” and 422.72(8) “a,” to be redacted prior to public inspection, the taxpayer must file a motion and affidavit meeting the requirements below.

a. Process for filing a motion for redaction of other details during a contested case. Motions for redaction of other details from a pleading, exhibit, attachment, motion or written evidence filed after the notice of hearing is issued in a contested case must comply with subrule 7.17(5).

b. Process for filing a motion for redaction of other details prior to the commencement of a contested case. Motions for redaction of other details from a pleading, exhibit, attachment, motion or written evidence filed prior to a contested case must be filed with the clerk of the hearings section of the department. The motion must be filed separately from the appeal described in subrule 7.9(6).

c. Contents of motion. Motions filed under this rule, including those filed during contested cases, shall contain the following:

(1) The name of the person requesting redaction and the docket number of the proceeding.

(2) Clear and convincing evidence that the disclosure would reveal a trade secret or would constitute a clear, unwarranted invasion of personal privacy. Corporations, limited liability companies, other business entities (including but not limited to partnerships and joint ventures), and trusts do not have protectible personal privacy interests.

(3) An unredacted copy of the document containing the information at issue and also a copy of the document with the desired redaction made. If a copy of the document is not in the possession of the taxpayer, the motion must contain a precise description of the document in the possession of the department from which the redaction is sought and a precise description of the information to be redacted. If redaction is sought from more than one document, each document and the information sought to be redacted shall be listed in separate paragraphs.

(4) For each item for which redaction is requested, an explanation of the legal basis for the redaction requested, including an explanation of why the release of the information sought to be redacted is a clear, unwarranted invasion of personal privacy or a trade secret.

(5) An affidavit in support of redaction. The affidavit must:

1. Be sworn to by a person familiar with the facts asserted within it and shall contain a clear and concise explanation of the facts justifying redaction, not merely the legal basis for redaction or conclusory allegations.

2. Contain a general and truthful statement that the information sought to be redacted is not available to the public from any source or combination of sources, direct or indirect, and a general statement that the release would serve no public purpose.

d. Burden of proof. The burden of showing that redaction is justified is on the movant. The burden is not carried by mere conclusory statements or allegations, for example, that the release of the material would be a clear, unwarranted invasion of personal privacy or that the material is a trade secret.

e. Contested case proceeding. That the information sought to be redacted is part of the pleadings, motions, evidence, and the record in a contested case proceeding otherwise open for public inspection and that the matter would otherwise constitute confidential tax information is not grounds for redaction.

7.7(3) *Process for requesting redaction of other details in a final order, decision, or ruling.* Motions to redact information from a final order, decision, or ruling cannot be made until the order is issued and must be made within 30 days of the date of the order, decision, or ruling. The taxpayer must follow the requirements in paragraph 7.7(2)“c” and subrule 7.18(5). The department has 30 days to respond to the motion from the date the department’s representatives receive notice from the presiding officer unless otherwise ordered by the presiding officer.

7.7(4) *Rulings.* Motions filed with the clerk of the hearings section will be ruled on by the director or may be referred by the director to an administrative law judge. Motions filed with the administrative law judge will be ruled on by the administrative law judge. In the case of motions before the director prior to contested case proceedings, the department may respond in writing to a motion on the request of the director or upon the initiative by department staff. Oral argument, including a hearing, may be held at the discretion of the presiding officer. The presiding officer may choose to close a hearing or other proceeding that may otherwise be open to the public due to the confidential nature of information covered by the motion during the pending motion.

7.7(5) *Limitation on motions.* If the motion or request is denied, the movant may not submit a motion to redact the same identifying details unless the movant is in possession of new information that may support the requested redaction(s) that the movant was not or could not have been aware of at the time of the original motion.

7.7(6) *Handling of the file while the motion is pending.* While a motion is pending, unless otherwise required or permitted by law, the department will treat the motion as if it has been granted and will not publicly release any information pursuant to Iowa Code chapter 22 or 17A sought to be kept confidential by the taxpayer.

This rule is intended to implement Iowa Code chapter 17A and sections 422.20(5) and 422.72(8).
[ARC 8944C, IAB 2/19/25, effective 3/26/25]

701—7.8(17A) Tax appeals. Any person wishing to contest an assessment, denial of refund claim, or any other department action, except licensing, which may culminate in a contested case proceeding, shall file an appeal, in writing, with the department within the time prescribed by the applicable statute or rule for filing notice of application to the director for a hearing. The appeal must be filed as described in rule 701—7.3(17A).

7.8(1) *Deadlines.* The period for appealing department action relating to refund claims is the same statutory period as that for contesting an assessment. Failure to timely file a proper appeal will

be construed as a waiver of opposition to the matter involved unless, on the director's own motion, pursuant to statutory authority, the powers of abatement or settlement are exercised.

7.8(2) *Paying an assessment that is divisible.* When an assessment involves divisible taxes that are not timely appealed, namely, an assessment that is divisible into a tax on each transaction or event, the taxpayer may contest the assessment by paying a portion of the assessment and filing a refund claim within the time period provided by law. In this latter instance, the portion paid must represent any undisputed portion of the assessment and must also represent the liability on a transaction or event for which, if the taxpayer is successful in contesting the portion paid, the unpaid portion of the assessment attributable to that specific type of transaction would be canceled. Any such appeal filed is limited to the issues covered by the amounts paid for which a refund was requested and denied by the department. If the department does not grant or deny the refund within six months of the filing of the refund claim or if the department denies the refund, the taxpayer may file an appeal as authorized by this rule.

7.8(3) *Types of divisible taxes.* All of the taxes administered and collected by the department can be divisible taxes, except individual income tax, fiduciary income tax, corporation income tax, franchise tax, partnership income, S corporation income, composite, and statewide property tax. The following noninclusive examples illustrate the application of the divisible tax concept:

EXAMPLE A: As a responsible party, X is assessed withholding income taxes, penalty, and interest on eight employees. X fails to timely appeal the assessment. X contends that X is not a responsible party. If X is a responsible party, X is required to make monthly deposits of the withholding taxes. In this situation, the withholding taxes are divisible. Therefore, X may pay an amount of tax, penalty, and interest attributable to one employee for one month and file a refund claim within the time period provided by law since, if X is successful on the refund claim, the remaining unpaid portion of the assessment would be canceled.

EXAMPLE B: Y is assessed sales tax, interest, and penalty for electricity purchased and used to power a piece of machinery in Y's manufacturing plant. Y fails to timely appeal the assessment. Y was billed monthly for electricity by the power company to which Y had given an exemption certificate. Y contends that the particular piece of machinery is used directly in processing tangible personal property for sale and that, therefore, all of the electricity is exempt from sales tax. In this situation, the sales tax is divisible. Therefore, Y may pay an amount of tax, penalty, and interest attributable to one month's electrical usage in that machinery and file a refund claim within the time period provided by law since, if Y is successful on the refund claim, the remaining unpaid portion of the assessment would be canceled.

7.8(4) *Who may be named in an appeal.* The appeal shall be brought in the name of the aggrieved taxpayer. Each aggrieved taxpayer may protest more than one agency action in a single appeal, subject to the applicable statutory appeal period for each protested agency action. Individuals or entities required to file separate tax returns or those choosing to file separate tax returns may not combine appeals with any other individual or entity. Taxpayers who are not named in the department action under appeal are not aggrieved taxpayers and may not be included in the appeal. The appeal may be filed by and in the name of the aggrieved taxpayer or by the authorized representative described in Iowa Code section 421.59(2), Iowa Code chapter 633B, or subrule 8.8(6) legally entitled to institute a proceeding on behalf of the person or by an intervenor in contested case proceedings. In the event of a discrepancy between the name set forth in the appeal and the correct name, a statement of the reason for the discrepancy shall be set forth in the appeal.

7.8(5) *Form and content of the appeal.*

a. Department forms. Appeals may be filed using the form available on GovConnectIowa or the form available on the department's website: revenue.iowa.gov/forms.

b. Manually created appeals. Persons who do not use GovConnectIowa or the form available on the department's website shall use the following format:

(1) The appeal shall contain a caption in the following form:

BEFORE THE DEPARTMENT OF REVENUE
HOOVER STATE OFFICE BUILDING
DES MOINES, IOWA

IN THE MATTER OF _____	*	
(state taxpayer's name and address and	*	APPEAL
designate type of proceeding, e.g.,	*	Docket No. _____
income tax refund claim)	*	(filled in by Department)

- (2) The appeal shall substantially state in separate numbered paragraphs the following:
1. Proper allegations showing:
 - Date of department action, such as the notice of assessment or refund denial;
 - Whether the taxpayer failed to timely appeal the assessment and, if so, the date of payment and the date of filing of the refund claim;
 - Whether the appeal involves the appeal of a refund claim after six months from the date of filing the refund claim because the department failed to deny the claim;
 - Copies of the documented department action, such as the notice of assessment, refund claim, and refund denial letter;
 - Other items that the taxpayer wishes to bring to the attention of the department; and
 - A request for attorney fees, if applicable.
 2. The type of tax, the taxable period or periods involved, and the amount in controversy.
 3. Each error alleged to have been committed, listed in a separate paragraph. For each error listed, an explanation of the error and all relevant facts related to the error shall be provided.
 4. Reference to any particular statute or statutes and any rule or rules involved, if known.
 5. Description of records or documents that were not available or were not presented to department personnel prior to the filing of the appeal, if any. Copies of any records or documents that were not previously presented to the department shall be provided.
 6. Any other matters deemed relevant and not covered in the above paragraphs.
 7. A statement setting forth the relief sought by the taxpayer.
 8. The signature of the taxpayer or the authorized representative. If the appeal is signed by the taxpayer, the address and telephone number of the taxpayer is to be included in the signature block. If the appeal is signed by an authorized representative, the address and telephone number of the authorized representative is to be included in the signature block. Appeals submitted by an authorized representative must have a valid IDR power of attorney form or representative certification form, as applicable in accordance with rule 701—8.8(17A,22,421,422), on file with the department, or one should be included with the appeal.
- c. Spouses.* If an appeal involves an assessment or a refund denial to a married couple and both spouses intend to appeal, both spouses must sign the document as drafted under paragraph 7.8(5) “a” or “b.” Appeals submitted by an authorized representative must include an executed IA 2848 power of attorney form or representative certification form, as applicable, for each spouse unless an IA 2848 power of attorney form or representative certification form is on file with the department.

7.8(6) Amendments.

- a.* Subject to the statutory appeal period, the taxpayer may amend the appeal at any time before a responsive pleading is filed. Amendments to the appeal after a responsive pleading has been filed may be allowed by the presiding officer, subject to the statutory appeal period, with the consent of the other parties or at the discretion of the presiding officer who may impose terms or grant a continuance.
- b.* The department may request that the taxpayer amend the appeal for purposes of clarification or to comply with format requirements. If the taxpayer fails to amend the appeal within the time provided for in the department's request, the department may move to dismiss the appeal under paragraph 7.11(3) “a.” Requests by the department to the taxpayer to amend the appeal after a

responsive pleading has been filed may be allowed by the presiding officer, subject to the statutory appeal period, with the consent of the other parties or at the discretion of the presiding officer who may impose terms or grant a continuance.

7.8(7) *Alcohol and lottery appeals.* This chapter does not apply to appeals and contested case proceedings for matters under the Iowa alcoholic beverage control Act (Iowa Code chapter 123) or the Iowa lottery act (Iowa Code chapter 99G). Information about appeals under those chapters is contained in 701—Chapter 6.

This rule is intended to implement Iowa Code chapter 17A.

[ARC 8944C, IAB 2/19/25, effective 3/26/25; ARC 0321D, IAB 5/27/26, effective 7/1/26]

701—7.9(17A) Resolution of tax liability. In the event that a proper appeal has been filed, other department personnel, when authorized by the enforcement actions and appeals bureau, have the authority to discuss the resolution of any matter in the appeal either with the taxpayer or the taxpayer's representative. The personnel shall report their activities in this regard to the enforcement actions and appeals bureau, and the bureau shall be authorized to approve or reject any recommendations made by the appropriate personnel to resolve an appeal.

This rule is intended to implement Iowa Code chapter 17A.

[ARC 8944C, IAB 2/19/25, effective 3/26/25; ARC 0321D, IAB 5/27/26, effective 7/1/26]

701—7.10(17A) Informal stage of the tax appeals process. When an appeal is filed, the parties are encouraged to utilize the informal procedures described in this rule to reach a resolution between the parties without the necessity of initiating contested case proceedings. That resolution may be the granting of the appeal in full or in part, the denial of the appeal in full or in part, or an agreement to settle the matter. Unless, in accordance with rule 701—7.12(17A,421), the taxpayer demands a contested case proceeding or the department waives informal procedures upon notification to the taxpayer, such informal procedures will be initiated as herein provided upon the filing of a proper appeal.

7.10(1) *Enforcement actions and appeals bureau review.* After an appeal is filed, the review unit, subject to the control of the director or the division administrator of the legal services division, will:

- a. Review and evaluate the validity of the appeal.
- b. Determine the correct amount of tax owing or refund due.
- c. Determine the best method of resolving the dispute between the taxpayer and the department.
- d. Take further action regarding the appeal, including any additions to and deletions from the audit, as may be warranted by the circumstances to resolve the appeal, including a request for an informal conference.
- e. Determine whether the appeal complies with rule 701—7.8(17A) and request any amendments to the appeal or additional information.

7.10(2) *Determinations, conferences.* The review unit may concede any items contained in the appeal that it determines should not be controverted by the department. If the taxpayer has not waived informal procedures, the review unit may request that the taxpayer and the taxpayer's representative, if any, attend an informal conference with the review unit to explore the possibility of reaching a settlement without the necessity of initiating contested case proceedings or the possibility of narrowing the issues presented in the appeal if no settlement can be made. The review unit may request clarification of the issues from the taxpayer or further information from the taxpayer or third persons.

7.10(3) *Findings.* A position letter addressing the issues raised in the appeal may be issued to the taxpayer or taxpayer's representative unless the issues may be more expeditiously determined in another manner or it is determined that such a letter is unnecessary.

7.10(4) *Format of review.* Nothing herein will prevent the review unit and the taxpayer from mutually agreeing on the manner in which the appeal will be informally reviewed.

7.10(5) Settlements. Only the director, a deputy director, the division administrator of the legal services division, or another person designated in writing by the director may approve and sign settlements of appeals. If a settlement is reached during informal procedures, a closing order stating that a settlement was reached by the parties and that the case is terminated shall be issued by the director and provided to all parties.

This rule is intended to implement Iowa Code section 17A.10.

[ARC 8944C, IAB 2/19/25, effective 3/26/25; ARC 0321D, IAB 5/27/26, effective 7/1/26]

701—7.11(17A,421) Dismissal of tax appeals.

7.11(1) Appeals filed after expiration of statutory deadline. Appeals that are not filed by the applicable statutory deadline shall be dismissed by the director or the director's designee in accordance with the procedure outlined in paragraph 7.11(1) "a."

a. Procedures for motions to dismiss. The department shall file a motion to dismiss with the clerk and serve a copy of the motion on the taxpayer. The taxpayer may file a resistance to the motion in writing within 20 days of the date of service of the motion. If no resistance is so filed, the director or the director's designee shall immediately enter an order dismissing the appeal. Once such dismissal order is entered, the director or the director's designee shall close the appeal. If a resistance is filed, the department has ten days from the date of the filing of the resistance to decide whether to withdraw its motion and so notify the taxpayer and the clerk. If no such notice is received by the clerk within the ten-day period, the appeal file will be transferred to the division of administrative hearings, which shall issue a notice for a contested case proceeding on the motion as prescribed by rule 701—7.15(17A), except that the issue of the contested case proceeding shall be limited to the question of whether the appeal was filed within the statutory appeal period. Thereafter, rule 701—7.18(17A) pertaining to contested case proceedings shall apply in such dismissal proceedings.

b. Grounds for denying the department's motion. The department's motion shall be granted unless the taxpayer can prove that it filed the appeal prior to the expiration of the statutory appeal deadline because the department failed to:

(1) Mail or personally deliver the notice of assessment, refund denial, or other notice of department action to the taxpayer's last-known address; or

(2) If applicable, also mail the notice of assessment, refund denial, or other notice of department action to the taxpayer's authorized representative; or

(3) Comply with the requirements of Iowa Code section 421.60(2) "b."

For purposes of this rule, "last-known address" and "personal delivery" mean the same as described in rule 701—7.23(421).

7.11(2) Appeals not authorized by statute. Appeals that are not authorized by statute or otherwise are inconsistent with the statutory requirements for an appeal shall be dismissed by the director in accordance with the procedure outlined in paragraph 7.11(1) "a," except that the issue shall be limited to the question of whether the appeal is authorized by statute and consistent with statutory appeal requirements.

7.11(3) Failure to pursue the appeal at the informal stage. If the appeal was filed timely and informal procedures were initiated, the failure of the taxpayer to provide documents or information requested by the department, including the failure to respond to a position letter or an information request, shall constitute failure to pursue the appeal and is grounds for the department to dismiss the appeal in accordance with the procedure outlined in paragraph 7.11(3) "a." For purposes of this subrule, an evasive or an incomplete response will be treated as a failure to pursue the appeal.

a. Procedures for motions to dismiss. If the department seeks to dismiss the appeal, the department shall file a motion to dismiss with the clerk and serve a copy of the motion on the taxpayer. The taxpayer may file a resistance to the motion within 20 days of the date of service of the motion. If no resistance is so filed, the director or the director's designee shall immediately enter an order dismissing the appeal. If a resistance is filed, the department has ten days from the date of the filing of the resistance to decide whether to withdraw its motion and so notify the taxpayer and

the clerk. If no such notice is received by the clerk within the ten-day period, the appeal file will be transferred to the division of administrative hearings, which shall issue a notice for a contested case proceeding on the motion as prescribed by rule 701—7.15(17A), except that the issue of the contested case proceeding shall be limited to the question of whether the taxpayer failed to pursue the appeal, as that term is defined in this subrule. Thereafter, rule 701—7.18(17A) pertaining to contested case proceedings shall apply in such dismissal proceedings.

b. Grounds for reinstatement of dismissed appeals. If a motion to dismiss is filed and is unresisted, the appeal that was dismissed may be reinstated by the director or the director's designee for good cause if an application for reinstatement is filed with the clerk within 30 days of the date the appeal was dismissed. For purposes of this rule, "good cause" means the same as "good cause" in Iowa Rule of Civil Procedure 1.977.

c. Content and review of the application for reinstatement. The application shall set forth all reasons and facts upon which the taxpayer relies in seeking reinstatement of the appeal. Supporting documentation must be supplied. The department shall review and notify the taxpayer whether the application is granted or denied.

d. Denial of the application. If the department denies the application to reinstate the appeal, the taxpayer has 30 days from the date the application for reinstatement was denied in which to request, in writing, a formal hearing on the reinstatement. The taxpayer shall send the written request to the clerk. When a written request for formal hearing is received, the appeal file will be transferred to the division of administrative hearings, which shall issue a notice as prescribed in rule 701—7.15(17A), except that the issue of the contested case proceeding shall be limited to the question of whether the taxpayer has good cause to reinstate the dismissed appeal. Thereafter, rule 701—7.18(17A) pertaining to contested case proceedings shall apply in such reinstatement proceedings. If the taxpayer does not respond to a denial of the application for reinstatement within 30 days of the denial, the director or the director's designee will issue an order closing the appeal.

e. Failure to file timely application for reinstatement. If an application for reinstatement is filed after the 30-day deadline, the application shall not be accepted by the director or director's designee.

7.11(4) Dismissal of appeals during contested case proceedings. Once contested case proceedings have been commenced, it shall be grounds for a motion to dismiss that a taxpayer has either failed to diligently pursue the appeal or has refused to comply with requests for discovery set forth in rule 701—7.16(17A). Such a motion must be filed with the presiding officer.

This rule is intended to implement Iowa Code sections 17A.12, 421.10, 421.60, and 422.28.

[ARC 8944C, IAB 2/19/25, effective 3/26/25]

701—7.12(17A,421) Demand for contested case proceeding. Pursuant to Iowa Code section 421.60(2) "g," a taxpayer may make a written demand for a contested case proceeding after a period of six months from the filing of a proper appeal. Demands made prior to six months will be treated as premature and must be resubmitted six months or later from the filing of the appeal. Upon receipt of a timely written demand, the department shall file its answer within 30 days after receipt of the demand. If the department fails to file its answer within this 30-day period, interest shall be applied in the manner described in the introductory paragraph of rule 701—7.13(17A).

This rule is intended to implement Iowa Code sections 17A.12 and 421.60.

[ARC 8944C, IAB 2/19/25, effective 3/26/25]

701—7.13(17A) Answer. If the parties are unable to resolve the appeal informally, or if the parties waive informal proceedings as described in rule 701—7.12(17A,421), the department shall file an answer to the appeal with the clerk. Subject to the limitations in rule 701—7.12(17A,421), the department will file an answer within 30 days of receipt of written demand for a contested case hearing from the taxpayer. In the case of an appeal of an assessment, failure to answer within the 30-day time period and after a demand for hearing has been made shall result in the suspension of interest from the time that the department was required to answer until the date that the department files its answer. In the case of an appeal of a refund denial, failure to answer within the 30-day time

period after a demand for hearing has been made shall result in the accrual of interest payable to the taxpayer at double the rate in effect under Iowa Code section 421.7 from the time the department was required to answer until the date that the department files its answer. Failure to file an answer within 30 days after the demand for contested case will not result in a default judgment for the taxpayer.

7.13(1) The answer of the department shall be drawn in a manner as provided by the Iowa Rules of Civil Procedure for answers filed in Iowa district courts.

7.13(2) Each paragraph contained in the answer shall be numbered or lettered to correspond, where possible, with the paragraphs of the appeal. The answer shall be signed by the department's counsel or representative.

7.13(3) The department shall promptly serve a copy of the answer upon the representative of record or, if there is no representative of record, upon the taxpayer. The department may amend its answer at any time prior to the commencement of the evidentiary hearing in response to the filing of an amended appeal or to assert a new matter or an affirmative defense. The presiding officer has discretion to grant a continuance to avoid prejudice to the taxpayer or the department.

7.13(4) The provisions of this rule shall be considered as a part of the informal procedures since a contested case proceeding, at the time of the filing of the answer, has not yet commenced. However, an answer shall be filed pursuant to this rule whether or not informal procedures have been waived by the taxpayer or the department.

7.13(5) The department's answer may contain a statement setting forth whether the case should be transferred to the division of administrative hearings or the director should retain the case for hearing.

7.13(6) The department's answer should set forth the basis for retention of the case by the director as provided in subrule 7.18(1). If the answer fails to allege that the case should be retained by the director, the case should be transferred to the division of administrative hearings for contested case proceedings unless the director determines on the director's own motion that the case should be retained by the director.

7.13(7) Upon the filing of an answer, the clerk will transfer the appeal file to the division of administrative hearings within 30 days of the date of the filing of the answer unless the director determines not to transfer the case. If a party objects to a determination under rule 701—7.18(17A), the transfer, if any, would be made after the director makes a ruling on the objection.

This rule is intended to implement Iowa Code chapter 17A and section 421.60.

[ARC 8944C, IAB 2/19/25, effective 3/26/25]

701—7.14(17A) Subpoenas. Prior to the commencement of a contested case, the department has the authority to subpoena books, papers, and records and has all other subpoena powers conferred upon it by law. Subpoenas in this case shall be issued by the director or the director's designee. Once a contested case is commenced, subpoenas must be issued by the presiding officer.

This rule is intended to implement Iowa Code sections 17A.13, 421.9, 421.17, and 422.70.

[ARC 8944C, IAB 2/19/25, effective 3/26/25]

701—7.15(17A) Commencement of contested case. A demand or request by the taxpayer for the commencement of contested case proceedings must be in writing and filed with the clerk by email to the address provided in paragraph 7.3(1)“b”; by mail via the United States Postal Service or common carrier by ordinary, certified, or registered mail in care of the clerk to the address listed in paragraph 7.3(1)“c”; or by personal service to the department's customer service desk as described in paragraph 7.3(1)“d.” Alternatively, a taxpayer that has a GovConnectIowa account may notify the clerk by using the Manage Appeal option in GovConnectIowa. The demand must be made no sooner than six months after the filing of the appeal. If the demand or request does not indicate a postmark date, then the date of receipt or the date personal service is made is considered the date of filing. Iowa Code section 622.105 describes the evidence necessary to establish proof of mailing.

7.15(1) When requesting a contested case hearing with the division of administrative hearings, the department shall complete a transmittal form consistent with rule 481—10.4(10A). The transmittal form is merely an administrative tool intended to facilitate the issuance of the notice of hearing.

7.15(2) At the request of a party or the presiding officer made prior to the issuance of the hearing notice, the presiding officer shall hold a telephone conference with the parties for the purpose of identifying the issues within the scope of the contested case, scheduling the hearing date, establishing discovery or other deadlines, and other procedural matters to be addressed in the notice of hearing. The notice of hearing shall be issued by the later of the following: within 30 days of the transmittal of the case from the department to the division of administrative hearings or one week after a telephone conference held under this subrule.

7.15(3) A contested case commences when the presiding officer delivers the notice of hearing by ordinary mail or electronic mail to the parties.

7.15(4) Any party may apply to the presiding officer for a continuance or a specific date for the hearing. The presiding officer may grant or deny such requests.

a. The notice of hearing shall include:

(1) A statement of the time (which shall allow for a reasonable time to conduct discovery), place and nature of the hearing;

(2) A statement of the legal authority and jurisdiction under which the hearing is held;

(3) A reference to the particular sections of the statutes and rules involved; and

(4) A short and plain statement of the matters asserted, including the issues.

b. The statement of the issues in the notice of hearing shall not include issues that are not presented in the appeal or the answer.

7.15(5) After the delivery of the notice commencing the contested case proceedings, the parties may file further pleadings or amendments to pleadings in accordance with this chapter.

This rule is intended to implement Iowa Code section 17A.12.

[ARC 8944C, IAB 2/19/25, effective 3/26/25]

701—7.16(17A) Discovery.

7.16(1) The rules of the supreme court of the state of Iowa applicable in civil proceedings with respect to depositions upon oral examination or written questions; written interrogatories; production of documents or things or permission to enter upon land or other property, for inspection and other purposes; physical and mental examinations; and requests for admission shall apply to discovery procedures in contested cases.

7.16(2) Disputes concerning discovery shall be resolved by the presiding officer. If necessary, a hearing shall be scheduled, with reasonable notice to the parties, and, upon hearing, an appropriate order shall be issued by the presiding officer.

7.16(3) When the department relies on a witness in a contested case, whether or not the witness is a departmental employee, who has made prior statements or reports with respect to the subject matter of the witness' testimony, the department shall, on request, make such statements or reports available to a party for use on cross-examination unless those statements or reports are otherwise expressly exempt from disclosure by constitution or statute.

7.16(4) Identifiable department records that are relevant to disputed material facts involved in a contested case shall, upon request, promptly be made available to the party unless the requested records are expressly exempt from disclosure by constitution or statute.

This rule is intended to implement Iowa Code chapter 17A.

[ARC 8944C, IAB 2/19/25, effective 3/26/25]

701—7.17(17A) Prehearing conference.

7.17(1) Following the commencement of the contested case and upon the motion of the presiding officer, or upon the written request of a party, the presiding officer shall direct the parties to appear at a specified time and place before the presiding officer for a prehearing conference to consider:

- a.* The possibility or desirability of waiving any provisions of the Act relating to contested cases by written stipulation representing an informed mutual consent;
- b.* The necessity or desirability of setting a new date for hearing;
- c.* The simplification of issues;
- d.* The necessity or desirability of amending the pleadings, subject to the applicable statute of limitations and the applicable statutory appeal period;
- e.* The possibility of agreeing to the admission of facts, documents or records not controverted, to avoid unnecessary introduction of proof;
- f.* The procedure at the hearing;
- g.* Limiting the number of witnesses;
- h.* The names and identification of witnesses and the facts each party will attempt to prove at the hearing;
- i.* Conduct or schedule of discovery; and
- j.* Such other matters as may aid, expedite or simplify the disposition of the proceeding.

7.17(2) Any action taken at the prehearing conference shall be recorded in an order unless the parties enter into a written stipulation as to such matters or agree to a statement thereof made on the record by the presiding officer.

7.17(3) When an order is issued at the termination of the prehearing conference, a reasonable time shall be allowed for the parties to present objections on the grounds that the order does not fully or correctly embody the agreements made at such conference. Thereafter, the terms of the order or modification thereof shall determine the subsequent course of the proceedings relative to matters the order includes unless modified to prevent manifest injustice.

7.17(4) If either party to the contested case fails to appear at the prehearing conference without requesting a continuance and without submitting evidence or arguments that the party wishes to be considered in lieu of appearance, the opposing party may move for dismissal. The motion shall be made in accordance with subrule 7.18(5).

This rule is intended to implement Iowa Code section 17A.12.

[ARC 8944C, IAB 2/19/25, effective 3/26/25]

701—7.18(17A) Contested case procedures.

7.18(1) *Evidentiary hearing.* Unless the parties to a contested case proceeding have, by written stipulation representing an informed mutual consent, waived the provisions of the Act relating to such proceedings, contested cases shall culminate in an evidentiary hearing open to the public.

a. Evidentiary hearings in which the presiding officer is an administrative law judge employed by the division of administrative hearings shall be held at the location designated in the notice of evidentiary hearing.

b. If the director retains a contested case, the location for the evidentiary hearing will generally be at the main office of the department at the Hoover State Office Building, First Floor, Des Moines, Iowa 50319. However, the department retains the discretion to change the location of the evidentiary hearing if necessary. The location of the evidentiary hearing will be designated in the notice of hearing issued by the director.

7.18(2) *Determination of presiding officer.* If the director retains a contested case for evidentiary hearing and the department is a party, the initial presiding officer will be the director. Upon determining that a case will be retained and not transferred to the division of administrative hearings, the director shall issue to the parties a written notification of the determination that states the basis for retaining the case for evidentiary hearing.

a. The director may determine to retain a contested case for evidentiary hearing and decision upon the filing by the department of its answer under rule 701—7.13(17A). If the answer failed to allege that the case should be retained by the director and the case was transferred to the division of administrative hearings for contested case proceedings, either party may, within a reasonable time after the issuance of the hearing notice provided in rule 701—7.15(17A), make application to the

director to recall and retain the case for hearing and decision. Any such application shall be served upon the assigned administrative law judge or presiding officer.

b. A taxpayer may file a written objection to the director's determination to retain the case for evidentiary hearing and may request that the contested case be heard by an administrative law judge or presiding officer and request a hearing on the objection. Such an objection must be filed with the clerk by email to the address provided in paragraph 7.3(1) "*b*," by mail via the United States Postal Service or common carrier by ordinary, certified, or registered mail in care of the clerk to the address listed in paragraph 7.3(1) "*c*," or by personal service to the department's customer service desk as described in paragraph 7.3(1) "*d*" within 20 days of the notice issued by the director of the director's determination to retain the case.

c. The director may retain the case only upon a finding that one or more of the following apply:

(1) One of the reasons listed in Iowa Code section 17A.11(1) "*a*."

(2) The case involves an issue or issues the resolution of which would create important precedent;

(3) The case involves complex or extraordinary questions of law or fact;

(4) The case involves issues or questions of law or fact that, based on the director's discretion, should be retained by the director;

(5) The request is not consistent with a specified statute; or

(6) Assignment of an administrative law judge will result in lengthening the time for issuance of a proposed decision, after the case is submitted, beyond a reasonable time as provided in subrule 7.18(8). In making this determination, the director shall consider whether the assigned administrative law judge has a current backlog of submitted cases for which decisions have not been issued for one year after submission.

d. The director shall issue a written order specifying the grounds for the decision within 20 days after a request for an administrative law judge is filed. If a party objects to the director's determination to retain a case for evidentiary hearing, transfer of the appeal file, if any, will be made after the director makes a final determination on the objection. If the ruling is contingent upon the availability of a qualified administrative law judge, the parties shall be notified at least ten days prior to the hearing whether a qualified administrative law judge will be available.

e. If there is no factual conflict or credibility of evidence offered in issue, either party, after the contested case has been heard and a proposed decision is pending with a presiding officer other than the director for at least one year, may make application to the director to transfer the case to the director for decision. In addition, if one or more criteria listed in paragraph 7.18(2) "*c*" exist, the director, on the director's own motion, may issue a notice to the parties of the director's intention to transfer the case to the director for decision. The opposing party may file, within 20 days after service of such application or notice by the director, a resistance setting forth in detail why the case should not be transferred. If the director approves the transfer of the case, the director shall issue a final contested case decision. The director or a party may request that the parties be allowed to submit proposed findings of fact and conclusions of law.

f. The director has the right to require that any presiding officer, other than the director, be a licensed attorney in the state of Iowa unless the contested case only involves licensing. In addition, any presiding officer must possess, upon determination by the director, sufficient technical expertise and experience in the areas of taxation and presiding over proceedings to effectively determine the issues involved in the proceeding.

g. Except as provided otherwise by another provision of law, all rulings by an administrative law judge acting as presiding officer are subject to appeal to the director.

7.18(3) *Conduct of proceedings.*

a. A proceeding shall be conducted by a presiding officer who shall:

(1) Open the record and receive appearances;

(2) Administer oaths and issue subpoenas;

(3) Enter the notice of hearing into the record;

- (4) Receive testimony and exhibits presented by the parties;
- (5) In the presiding officer's discretion, interrogate witnesses;
- (6) Rule on objections and motions;
- (7) Close the hearing; and
- (8) Issue an order containing findings of fact and conclusions of law.

b. The presiding officer may resolve preliminary procedural motions by telephone or videoconference in which all parties have an opportunity to participate. Other telephone or video proceedings may be held with the consent of all parties. The presiding officer will determine the location of the parties and witnesses for telephone or video hearing. The convenience of the witnesses or parties, as well as the nature of the case, will be considered when location is chosen. Parties shall be notified at least 30 days in advance of the date and place of the hearing.

c. Evidentiary proceedings shall be oral, open to the public, and recorded either by electronic means or by certified shorthand reporters. Parties requesting that the hearing be recorded by certified shorthand reporters bear the costs of reporting. The record of the oral proceedings or the transcription thereof shall be filed with and maintained by the department for at least five years from the date of the decision. An opportunity shall be afforded to the parties to respond and present evidence and argument on all issues involved and to be represented by counsel at their own expense. Unless otherwise directed by the presiding officer, evidence will be received in the following order:

- (1) Taxpayer,
- (2) Intervenor (if applicable),
- (3) Department,
- (4) Rebuttal by taxpayer,
- (5) Oral argument by parties (if necessary).

d. If the taxpayer or the department appears without counsel or other representative who can reasonably be expected to be familiar with these rules, the presiding officer shall explain to the parties the rules of practice and procedure and generally conduct a hearing in a less formal manner than that used when the parties have counsel or representation. It should be the purpose of the presiding officer to assist any party appearing without such representative to the extent necessary to allow the party to present evidence, testimony, and argument on the issues. The presiding officer shall take whatever steps may be necessary and proper to ensure that all evidence having probative value is presented and that each party is accorded a fair hearing.

e. If the parties have mutually agreed to waive the provisions of the Act in regard to contested case proceedings, the hearing will be conducted in a less formal manner than when an evidentiary hearing is conducted.

f. The presiding officer may enter a default decision as described in subrule 7.18(7).

g. Contemptuous conduct by any person appearing at a hearing shall be grounds for the person's exclusion from the hearing by the presiding officer.

7.18(4) Rules of evidence.

a. *Oath.* All testimony presented before the presiding officer shall be given under oath, which the presiding officer has authority to administer.

b. *Production of evidence and testimony.* The presiding officer may issue subpoenas to a party on request, as permitted by law, compelling the attendance of witnesses and the production of books, papers, records, or other real evidence.

c. *Subpoena.* When a subpoena is desired after the commencement of a contested case proceeding, the proper party shall indicate to the presiding officer the name of the case, the docket number, and the last-known mailing addresses of the witnesses to be called. If evidence other than oral testimony is required, each item to be produced must be adequately described. When properly prepared by the presiding officer, the subpoena will be returned to the requesting party for service. Service may be made in any manner allowed by law before the hearing date of the case that the witness is required to attend. No costs for serving a subpoena will be allowed if the subpoena is served

by any person other than the sheriff. Subpoenas requested for discovery purposes shall be issued by the presiding officer.

d. Admissibility of evidence.

(1) Evidence having probative value.

1. Although the presiding officer is not bound to follow the technical common law rules of evidence, a finding shall be based upon the kind of evidence on which a reasonably prudent person would rely for the conduct of the person's serious affairs and may be based upon such evidence even if it would be inadmissible in a jury trial. Therefore, the presiding officer may admit and give probative effect to evidence on which a reasonably prudent person would rely for the conduct of the person's serious affairs. Irrelevant, immaterial, or unduly repetitious evidence shall be excluded. The presiding officer shall give effect to the rules of privilege recognized by law. Evidence not provided to a requesting party through discovery shall not be admissible at the hearing. Subject to these requirements, when a hearing will be expedited and the interests of the parties will not be prejudiced, substantially any part of the evidence may be required to be submitted in verified written form by the presiding officer.

2. Objections to evidentiary offers may be made at the hearing, and the presiding officer's ruling thereon shall be noted in the record.

(2) Evidence of a federal determination of the taxpayer's liability. Evidence of a federal determination of the taxpayer's liability such as a treasury department ruling, regulation or determination letter issued to the taxpayer; a taxpayer's federal court decision; or an Internal Revenue Service assessment issued to the taxpayer relating to issues raised in the proceeding are admissible, and the taxpayer is presumed to have conceded the accuracy of the federal determination unless the taxpayer specifically states wherein it is erroneous.

(3) Copies of evidence. A copy of any book, record, paper or document may be offered directly in evidence in lieu of the original if the original is not readily available or if there is no objection. Upon request, the parties shall be given an opportunity to compare the copy with the original, if available.

(4) Stipulations. Approval of the presiding officer is not required for stipulations of fact to be used in contested case proceedings. In the event the parties file stipulations of fact in the proceedings, the stipulation is binding on the parties and the presiding officer.

e. Identification of exhibits. Exhibits that are offered by taxpayers and attached to a stipulation or entered in evidence shall be numbered serially, e.g., 1, 2, 3; exhibits offered by the department shall be lettered serially, e.g., A, B, C; and those offered jointly shall be numbered and lettered, e.g., 1-A, 2-B, 3-C.

f. Official notice. The official notice provisions of Iowa Code section 17A.14(4) apply to contested cases of the department.

g. Evidence outside the record. Except as provided by these rules, the presiding officer shall not consider factual information or evidence in the determination of any proceeding unless the same shall have been offered and made a part of the record in the proceeding.

h. Presentation of evidence and testimony. In any hearing, each party in attendance shall have the right to present evidence and testimony of witnesses and to cross-examine any witness who testifies on behalf of an adverse party. A person whose testimony has been submitted in written form shall, if available, also be subject to cross-examination by an adverse party. Opportunity shall be afforded each party for re-direct examination and re-cross-examination and to present evidence and testimony as rebuttal to evidence presented by another party, except that unduly repetitious evidence shall be excluded.

i. Offer of proof. An offer of proof may be made through the witness or by statement of counsel. The party objecting may cross-examine the witness without waiving any objection.

7.18(5) Motions.

a. Filing of motions after commencement of contested case proceedings. After commencement of contested case proceedings, appropriate motions may be filed with the presiding officer by any

party when facts requiring such motion come to the knowledge of the party. All motions shall state the relief sought and the grounds upon which the motions are based.

b. Service, rulings. Motions made prior to a hearing shall be in writing and a copy thereof served on all parties and attorneys of record. The presiding officer will rule on such motions by issuing a written order. A copy of the order containing the ruling on the motion shall be served on the parties and authorized representatives. A motion may be made orally during the course of a hearing; however, the presiding officer may request that the motion be reduced to writing and filed with the presiding officer.

c. Consent of the opposing party, burden. To avoid a hearing on a motion, it is advisable to secure the consent of the opposing party prior to filing the motion. If consent of the opposing party to the motion is not obtained, a hearing on the motion may be scheduled and the parties notified. The burden will be on the party filing the motion to show good cause as to why the motion should be granted.

d. Affidavits. The party making the motion may affix thereto such affidavits as are deemed essential to the disposition of the motion, which shall be served with the motion and to which the opposing party may reply with counter affidavits.

e. Resistance. The party opposing a motion, except in the case of motions for summary judgment, must file its resistance within ten days of the date of filing of the motion unless a presiding officer otherwise orders a different deadline to file the resistance.

f. Reply. The movant may file a reply within seven days of the date of filing of the resistance to the motion.

g. Types of motions. Types of motions include but are not limited to:

(1) Motion for continuance. Motions for continuance should be filed no later than ten days before the scheduled date of the contested case hearing unless the grounds for the motion are first known to the moving party within ten days of the hearing, in which case the motion shall be promptly filed and shall set forth why it could not be filed at least ten days prior to the hearing. Grounds for motion for continuance include, but are not limited to, the unavailability of a party, a party's representative, or a witness; the incompleteness of discovery; and the possibility of settlement of the case.

(2) Motion for dismissal.

(3) Motion for summary judgment.

(4) Motion for redaction of identifying details in the decision. More information is contained in rule 701—7.7(17A).

(5) Motion for default.

(6) Motion to vacate default.

h. Summary judgment procedure. Summary judgment may be obtained under the following conditions and circumstances:

(1) A party may move, with or without supporting affidavits, for summary judgment in the party's favor upon all or any part of a party's claim or defense.

(2) The motion shall be filed not less than 60 days prior to the date set for the contested case hearing unless otherwise ordered by the presiding officer. Any party resisting the motion shall file the following within 30 days of the date of filing of the motion: a resistance; a statement of disputed facts, if any; and a memorandum of authorities supporting the resistance. If affidavits supporting the resistance are filed, they must be filed with the resistance. The movant may reply to the resistance within 15 days of the date of filing of the resistance.

(3) Upon any motion for summary judgment pursuant to this rule, there shall be affixed to the motion a separate, short, and concise statement of the material facts as to which the moving party contends there is no genuine issue to be tried, including specific reference to those parts of the pleadings, depositions, answers to interrogatories, admissions on file, and affidavits that support such contentions and a memorandum of authorities.

(4) Supporting and opposing affidavits shall set forth such facts as would be admissible in evidence and shall show affirmatively that the affiant is competent to testify to the matters stated

therein. The presiding officer may permit affidavits to be supplemented or opposed by depositions, answers to interrogatories, further affidavits, or oral testimony. When a motion for summary judgment is made and supported as provided in this rule, an adverse party may not rest upon the mere allegations or denials of the party's pleading but the party's response must set forth specific facts, by affidavits or as otherwise provided in this rule, showing that there is a genuine issue for hearing. If the party does not so respond, summary judgment, if appropriate, shall be entered against the party.

(5) If, on motion under this rule, judgment is not rendered upon the whole case or for all the relief asked and a hearing is necessary, the presiding officer at the hearing of the motion, by examining the pleadings and the evidence before the presiding officer and by interrogating counsel, shall, if practicable, ascertain what material facts exist without substantial controversy and what material facts are actually and in good faith controverted. The presiding officer shall thereupon make an order specifying the facts that appear without substantial controversy, including the extent to which the amount or other relief is not in controversy, and directing such further proceedings in the action as are just. Upon the hearing of the contested case, the facts so specified shall be deemed established, and the hearing shall be conducted accordingly.

(6) Should it appear from the affidavits of a party opposing the motion that the party cannot present, by affidavit, facts essential to justify the party's opposition, the presiding officer may refuse the application for judgment, may order a continuance to permit affidavits to be obtained, may order depositions be taken or discovery be completed, or may make any other order appropriate.

(7) An order on summary judgment that disposes of less than the entire case is appealable to the director at the same time that the proposed order is appealable pursuant to subrule 7.18(8).

7.18(6) Briefs and oral argument.

a. At any time, upon the request of any party or in the presiding officer's discretion, the presiding officer may require the filing of briefs on any of the issues before the presiding officer prior to or at the time of hearing, or at a subsequent time. At the conclusion of hearing, the parties should be prepared to make oral arguments as to the facts and law if directed by the presiding officer.

b. A copy of all briefs shall be filed. Filed briefs shall conform to the requirements of subrules 7.5(1) and 7.5(2).

c. The parties may agree to a briefing schedule. If the parties agree to a briefing schedule and if the presiding officer adopts the agreed-upon briefing schedule by issuing an order to that effect, the schedule is binding on the parties and the presiding officer except that, for good cause shown, the time may be extended upon application of a party.

7.18(7) Defaults. If a party fails to appear or participate in a contested case proceeding after proper service of notice, the presiding officer may, if no adjournment is granted, enter a default decision or proceed with the hearing and render a decision in the absence of the party.

a. Where appropriate and not contrary to law, any party may move for default against a party who has failed to file a required pleading or has failed to appear after proper service.

b. A default decision or a decision rendered on the merits after a party failed to appear or participate in a contested case proceeding becomes a final department action unless, within 15 days after the date of notification or mailing of the decision, a motion to vacate is filed and served on all parties or an appeal of a decision on the merits is timely initiated within the time provided in subrule 7.18(8). A motion to vacate must state all facts relied upon by the moving party that establish that good cause existed for that party's failure to appear or participate at the contested case proceeding. Each fact so stated must be substantiated by at least one sworn affidavit of a person with personal knowledge of each such fact, and such affidavit(s) must be attached to the motion.

c. The time for further appeal of a decision for which a timely motion to vacate has been filed is stayed pending a decision on the motion to vacate.

d. Properly substantiated and timely filed motions to vacate shall be granted only for good cause shown. The burden of proof as to good cause is on the moving party. Adverse parties have ten days to respond to a motion to vacate. Adverse parties shall be allowed to conduct discovery as to the issue of

good cause and to present evidence on the issue prior to a decision on the motion, if a request to do so is included in that party's response.

e. For purposes of this rule, "good cause" means the same as "good cause" in Iowa Rule of Civil Procedure 1.977.

f. A decision denying a motion to vacate is subject to further appeal within the time limit allowed for further appeal of a decision on the merits in the contested case proceeding. A decision granting a motion to vacate is subject to interlocutory appeal by the adversely affected party as provided in subrule 7.18(11).

g. If a motion to vacate is granted and no timely interlocutory appeal has been taken, the presiding officer shall issue another notice of hearing and the contested case shall proceed accordingly.

h. A default decision may award any relief consistent with the request for relief by the party in whose favor the default decision is made and embraced in the contested case issues, but unless the defaulting party has appeared, the relief awarded cannot exceed the relief demanded.

i. A default decision may provide either that the default decision is to be stayed pending a timely motion to vacate or that the default decision is to take effect immediately, subject to a request for a stay.

7.18(8) Orders.

a. Proposed decisions submitted by parties. At the conclusion of the hearing, the presiding officer, in the presiding officer's discretion, may request the parties to submit proposed findings of fact and conclusions of law. Upon the request of any party, the presiding officer shall allow the parties an opportunity to submit proposed findings of fact and conclusions of law. In addition to or in lieu of the filing of briefs, upon the request of all of the parties waiving any contrary contested case provisions of law or of these rules, the presiding officer shall allow the parties to submit proposed findings of fact and conclusions of law, and the presiding officer may sign and adopt as the decision or proposed decision one of such proposed findings of fact and conclusions of law without any changes or with such changes that are supported by the record and law.

b. Preparing the proposed decision. The decision in a contested case is an order that shall be in writing or stated in the record. The order shall include findings of fact prepared by the presiding officer, unless the presiding officer is unavailable, and based solely on the evidence in the record and on matters officially noticed in the record and shall include conclusions of law. The findings of fact and conclusions of law shall be separately stated. If a party has submitted proposed findings of fact, the order shall include a ruling upon each proposed finding. Each conclusion of law shall be supported by cited authority or by a reasoned opinion. The decision must include an explanation of why the relevant evidence in the record supports each material finding of fact. If the issue of reasonable litigation costs was held in abeyance pending the outcome of the substantive issues in the contested case and the proposed order decides substantive issues in favor of the taxpayer, the proposed order shall include a notice of time and place for a hearing on the issue of whether reasonable litigation costs shall be awarded and on the issue of the amount of such award unless the parties agree otherwise. All decisions and orders in a contested case proceeding shall be based solely on the legal bases and arguments presented by the parties. In the event that the presiding officer believes that a legal basis or argument for a decision or order exists, but has not been presented by the parties, the presiding officer shall notify the parties and give them an opportunity to file a brief that addresses such legal basis or argument.

c. Decision on motions to redact identifying details. When a motion has been made to redact identifying details in an order on the basis of personal privacy or trade secrets, the justification for such redaction or refusal to redact shall be made by the moving party and shall appear in the order.

d. Proposed and final decisions. When the director initially presides at a hearing or considers decisions on appeal from or review of a proposed decision by the presiding officer other than the director, the order becomes the final order of the department for purposes of judicial review or rehearing unless there is an appeal to or review on motion of a second agency within the time

provided by statute or rule. When a presiding officer other than the director presides at the hearing, the order becomes final and not subject to judicial review unless there is an appeal to or review on motion of the director within 30 days of the date of the order, including Saturdays, Sundays, and holidays as defined in Iowa Code section 421.9A, or 10 days, excluding Saturdays, Sundays, and holidays as defined in Iowa Code section 421.9A, for a revocation order pursuant to rule 701—7.26(17A). However, if the contested case proceeding involves a question of an award of reasonable litigation costs, the proposed order on the substantive issues shall not be appealable to or reviewable by the director on the director's motion until the issuance of a proposed order on the reasonable litigation costs. If there is no such appeal to or review by the director within 30 days or 10 days, whichever is applicable, from the date of the proposed order on reasonable litigation costs, both the proposed order on the substantive issues and the proposed order on the reasonable litigation costs become final and not subject to judicial review. On an appeal from, review of, or application for rehearing concerning the presiding officer's order, the director has all the power which the director would initially have had in making the decision; however, the director will consider only those issues presented at the hearing before the presiding officer or raised independently by the presiding officer, including the propriety of and the authority for raising issues. The parties will be notified of those issues that will be considered by the director.

e. Application to review interlocutory decisions. Notwithstanding this rule, where a presiding officer other than the director issues an interlocutory decision or ruling which does not dispose of all the issues, except reasonable litigation costs, in the contested case proceeding, the party adversely affected by the interlocutory decision or ruling may apply to the director within 20 days (10 days for a revocation proceeding) of the date of issuance of the interlocutory decision or ruling to grant an appeal in advance of the proposed decision. The application shall be served on the parties and the presiding officer. The party opposing the application shall file any resistance within 15 days of the service of the application unless, for good cause, the director extends the time for such filing. The director, in the exercise of discretion, may grant the application on finding that such interlocutory decision or ruling involves substantial rights and will materially affect the proposed decision and that a determination of its correctness before hearing on the merits will better serve the interests of justice. The order of the director granting the appeal may be on terms setting forth the course of proceedings on appeal, including advancing the appeal for prompt submission, and the order shall stay further proceedings below. The presiding officer, at the request of the director, shall promptly forward to the director all or a portion of the file or record in the contested case proceeding.

f. Appeals to and reviews by director—notice to administrative hearings division. In the event of an appeal to or review of the proposed order by the director, the administrative hearings division shall be promptly notified of the appeal or review by the director. The administrative hearings division shall, upon such notice, promptly forward the record of the contested case proceeding and all other papers associated with the case to the director.

g. Director's authority in appeals and review of proposed decisions. On an appeal or review of a proposed decision, the director has all the power that the director would have in initially making the final decision except as it may limit the issues on notice to the parties. A decision by the director may reverse or modify any finding of fact if a preponderance of the evidence will support a determination to reverse or modify such a finding of fact or may reverse or modify any conclusion of law that the director finds to be in error.

h. Issuing orders. Orders will be issued within a reasonable time after termination of the hearing. Parties shall be promptly notified of each order by delivery to them of a copy of the order by personal service, regular mail, certified mail, return receipt requested, AEDMS as described in 481—Chapter 16, or any other method to which the parties may agree. For example, a copy of the order can be submitted by electronic mail if both parties agree.

i. Cross-appeals. A cross-appeal may be taken within the 30-day period for taking an appeal to the director or in any event within 5 days after the appeal to the director is taken. If a cross-appeal is taken from a revocation order pursuant to rule 701—7.26(17A), the cross-appeal may be taken within

the ten-day period for taking an appeal to the director or in any event within five days after the appeal to the director is taken.

j. Transmission of case from administrative hearings division back to the department. Upon issuance of a closing order or the proposed decision by a presiding officer other than the director, such presiding officer no longer has authority over the contested case, except to resolve taxpayer requests for awards of reasonable litigation costs. Thereafter, any further proceedings associated with or related to the contested case must occur before the director.

k. Exhaustion of administrative remedies required. A party may not seek judicial review until the director has issued a final decision of the agency. If a party seeks judicial review of a proposed decision of an administrative law judge without appealing to the director or without review of the proposed decision by the director, the party is deemed to have failed to exhaust adequate administrative remedies.

7.18(9) Stays.

a. During the pendency of judicial review of the final contested case order of the department, the party seeking judicial review may file with the director an application for a stay. The application shall set forth in detail the reasons why the applicant is entitled to a stay and shall specifically address the following four factors:

- (1) The extent to which the applicant is likely to prevail when the court finally disposes of the matter;
- (2) The extent to which the applicant will suffer irreparable injury if the stay is not granted;
- (3) The extent to which the granting of a stay to the applicant will substantially harm the other parties to the proceedings; and
- (4) The extent to which the public interest relied on by the department is sufficient to justify the department's actions in the circumstances.

b. The director shall consider and balance the previously mentioned four factors and may consult with department personnel and the department's representatives in the judicial review proceeding. The director shall expeditiously grant or deny the stay.

7.18(10) Costs.

a. A prevailing taxpayer in a contested case proceeding related to the determination, collection, or refund of a tax, penalty, or interest may be awarded by the department reasonable litigation costs incurred subsequent to the issuance of the notice of assessment or refund denial that are based upon the following:

- (1) The reasonable expenses of expert witnesses.
- (2) The reasonable costs of studies, reports, and tests.
- (3) The reasonable fees of independent attorneys or independent accountants retained by the taxpayer. No such award is authorized for accountants or attorneys who represent themselves or who are employees of the taxpayer.

b. An award for reasonable litigation costs shall not exceed \$25,000 per case.

c. No award shall be made for any portion of the proceeding which has been unreasonably protracted by the taxpayer.

d. For purposes of this subrule, "prevailing taxpayer" means a taxpayer who establishes that the position of the department in the contested case proceeding was not substantially justified and who has substantially prevailed with respect to the amount in controversy, or has substantially prevailed with respect to the most significant issue or set of issues presented. If the position of the department in issuance of the assessment or refund denial was not substantially justified and if the matter is resolved or conceded before the contested case proceeding is commenced, there cannot be an award for reasonable litigation costs.

e. The definition of "prevailing taxpayer" is taken from the definition of "prevailing party" in 26 U.S.C. §7430. Therefore, federal cases determining whether the Internal Revenue Service's position was substantially justified will be considered in the determination of whether a taxpayer is

entitled to an award of reasonable litigation costs to the extent that 26 U.S.C. §7430 is consistent with Iowa Code section 421.60(4).

f. The taxpayer has the burden of establishing the unreasonableness of the department's position.

g. Once a contested case has commenced, a concession by the department of its position or a settlement of the case either prior to the evidentiary hearing or any order issued does not, per se, either authorize an award of reasonable litigation costs or preclude such award.

h. If the department relied upon information provided or action conducted by federal, state, or local officials or law enforcement agencies with respect to the tax imposed by Iowa Code chapter 453B, an award for reasonable litigation costs shall not be made in a contested case proceeding involving the determination, collection, or refund of that tax.

i. The taxpayer who seeks an award of reasonable litigation costs must specifically request such award in the appeal, or the request for award will not be considered.

j. A request for an award of reasonable litigation costs shall be held in abeyance until the concession or settlement of the contested case proceeding, or the issuance of a proposed order in the contested case proceeding, unless the parties agree otherwise.

k. At the hearing held for the purpose of deciding whether an award for reasonable litigation costs should be awarded, consideration shall be given to the following points:

- (1) Whether the department's position was substantially justified;
- (2) Whether the taxpayer is the prevailing taxpayer;
- (3) Whether the taxpayer has established how the alleged reasonable litigation costs were incurred. The burden is upon the taxpayer to establish how the alleged reasonable litigation costs were incurred. This requires a detailed accounting of the nature of each cost, the amount of each cost, and to whom the cost was paid or owed;
- (4) Whether alleged litigation costs are reasonable or necessary;
- (5) Whether the taxpayer has met the taxpayer's burden of demonstrating all of these points.

7.18(11) *Interlocutory appeals.* Upon written request of a party or on the director's own motion, the director may review an interlocutory order of the presiding officer. In determining whether to do so, the director shall weigh the extent to which granting the interlocutory appeal would expedite final resolution of the case and the extent to which review of that interlocutory order by the director at the time of the review of the proposed decision of the presiding officer would provide an adequate remedy. Any request for interlocutory review must be filed within 14 days of issuance of the challenged order, but no later than the time for compliance with the order or the date of hearing, whichever is first.

7.18(12) *Consolidation and severance.*

a. Consolidation. The presiding officer may consolidate any or all matters at issue in two or more contested case proceedings where:

- (1) The matters at issue involve common parties or common questions of fact or law;
- (2) Consolidation would expedite and simplify consideration of the issues involved; and
- (3) Consolidation would not adversely affect the rights of any of the parties to those proceedings.

b. Severance. On motion by a party, the presiding officer may, for good cause shown, order any contested case or portions thereof severed. If the presiding officer severs one or more issues from the remaining issues in the contested case, the contested case proceeds only on the issues that the presiding officer ordered for resolution. Once the decision on the issues that the presiding officer ordered for resolution becomes final and is not subject to further appeals, the parties may proceed, if necessary, with contested case on the issues that the presiding officer severed.

c. Stipulations. Stipulations of fact are encouraged, but no party can be required to stipulate to any facts. Stipulations as to the law are invalid.

d. Informal disposition. Without the necessity of proceeding to an evidentiary hearing in a contested case, the parties may agree in writing to informally dispose of the case by stipulation, agreed settlement, or consent order or by another method agreed upon. If such informal disposition is utilized,

the parties shall so indicate to the presiding officer that the case has been settled. Upon request, the presiding officer shall issue a closing order to reflect such a disposition. The contested case is terminated upon issuance of a closing order.

e. Mutual waivers. Unless otherwise precluded by law, the parties in a contested case proceeding may mutually agree to waive any provision under this rule governing contested case proceedings.

This rule is intended to implement Iowa Code sections 17A.12, 17A.14, 17A.15, 421.60 and 452A.68.

[ARC 8944C, IAB 2/19/25, effective 3/26/25]

701—7.19(17A) Interventions. Interventions are governed by the Iowa Rules of Civil Procedure.

This rule is intended to implement Iowa Code chapter 17A.

[ARC 8944C, IAB 2/19/25, effective 3/26/25]

701—7.20(17A) Record and transcript.

7.20(1) The record in a contested case shall include:

- a.* All pleadings, motions, and rulings;
- b.* All evidence received or considered and all other submissions;
- c.* A statement of all matters officially noticed;
- d.* All questions and offers of proof, objections, and rulings thereon;
- e.* All proposed findings and exceptions;
- f.* All orders of the presiding officer; and
- g.* The order of the director on appeal or review.

7.20(2) Oral hearings regarding proceedings on appeal to or considered on motion of the director that are recorded by electronic means shall not be transcribed for the record of such appeal or review unless a party, by written notice, or the director, orally or in writing, requests such transcription. Such a request must be filed with the clerk who will be responsible for making the transcript. A transcription will be made only of that portion of the oral hearing relevant to the appeal or review if so requested and if no objection is made by any other party to the proceeding or the director.

7.20(3) Upon request, the department shall provide a copy of the whole record or any portion of the record at cost. The cost of preparing a copy of the record or of transcribing the hearing record shall be paid by the requesting party. Parties who request that a hearing be recorded by certified shorthand reporters rather than by electronic means bear the cost of that recording unless otherwise provided by law.

7.20(4) Upon issuance of a proposed decision that leaves no issues open for further consideration or upon issuance of a closing order, the administrative hearings division shall promptly forward the record of a contested case proceeding to the director. However, the administrative hearings division may keep the tapes of any evidentiary proceeding in case a transcript of the proceeding is required and, if one is required, the administrative hearings division shall make the transcription and promptly forward the tapes and the transcription to the director.

This rule is intended to implement Iowa Code section 17A.12.

[ARC 8944C, IAB 2/19/25, effective 3/26/25]

701—7.21(17A) Application for rehearing. Any party to a contested case may file an application with the director for a rehearing in the contested case with the clerk in one of the manners described in subrule 7.3(1), stating the specific grounds therefor and the relief sought. The application must be filed within 20 days after the final order is issued. A copy of such application shall be timely served by the applicant on all parties in conformity with rule 701—7.3(17A). The director shall have 20 days from the filing of the application for rehearing to grant or deny the application. If the application for rehearing is granted, a notice will be served on the parties stating the time and place of the rehearing. An application for rehearing is deemed denied if not granted by the director within 20 days after filing.

7.21(1) The application for rehearing shall contain a caption in the following form:

BEFORE THE DEPARTMENT OF REVENUE
HOOVER STATE OFFICE BUILDING
DES MOINES, IOWA

IN THE MATTER OF _____	*	
(state taxpayer's name and address and	*	APPLICATION FOR REHEARING
designate type of proceeding, e.g.,	*	Docket No. _____
income tax refund claim)	*	

7.21(2) The application for rehearing shall substantially state in separate numbered paragraphs the following:

- a.* Clear and concise statements of the reasons for requesting a rehearing and each and every error that the party alleges to have been committed during the contested case proceedings;
- b.* Clear and concise statements of all relevant facts upon which the party relies;
- c.* Reference to any particular statute or statutes and any rule or rules involved;
- d.* The signature of the party or that of the party's representative, the address of the party or of the party's representative, and the telephone number of the party or the party's representative.

7.21(3) No applications for rehearing shall be filed with or entertained by an administrative law judge.

This rule is intended to implement Iowa Code section 17A.16.

[ARC 8944C, IAB 2/19/25, effective 3/26/25]

701—7.22(17A) Ex parte communications and disqualification.

7.22(1) *Ex parte communication.* A party that has knowledge of a prohibited communication by any party or presiding officer should file a copy of the written prohibited communication or a written summary of the prohibited oral communication with the clerk. The clerk will transfer to the presiding officer the filed copy of the prohibited communication.

a. Prohibited communications. Unless required for the disposition of ex parte matters specifically authorized by statute, following issuance of the notice of hearing, there shall be no communication, directly or indirectly, between the presiding officer and any party or representative of any party or any other person with a direct or indirect interest in such case in connection with any issue of fact or law in the case except upon notice and opportunity for all parties to participate. This does not prohibit persons jointly assigned such tasks from communicating with each other. Nothing in this provision is intended to preclude the presiding officer from communicating with members of the department or seeking the advice or help of persons other than those with a personal interest in, or those engaged in personally investigating as defined in this rule, prosecuting, or advocating in, either the case under consideration or a pending factually related case involving the same parties as long as those persons do not directly or indirectly communicate to the presiding officer any ex parte communications they have received of a type that the presiding officer would be prohibited from receiving or that furnish, augment, diminish, or modify the evidence in the record. Prohibitions on ex parte communications commence with the issuance of the notice of hearing in a contested case and continue for as long as the case is pending.

b. "Ex parte" communication defined. Written, oral or other forms of communication are "ex parte" if made without notice and opportunity for all parties to participate.

c. How to avoid prohibited communications. To avoid prohibited ex parte communications, notice must be given in a manner reasonably calculated to give all parties a fair opportunity to participate. Notice of written communications shall be provided in compliance with this chapter and may be supplemented by telephone, facsimile, electronic mail, or other means of notification. Where

permitted, oral communications may be initiated through conference telephone calls including all parties or their representatives.

d. Joint presiding officers. Persons who jointly act as presiding officer in a pending contested case may communicate with each other without notice or opportunity for parties to participate.

e. Advice to presiding officer. Persons may be present in deliberations or otherwise advise the presiding officer without notice or opportunity for parties to participate as long as the parties are not disqualified from participating in the making of a proposed or final decision under any provision of law and the parties comply with these rules.

f. Procedural communications. Communications with the presiding officer involving uncontested scheduling or procedural matters do not require notice or opportunity for parties to participate. Parties should notify other parties prior to initiating such contact with the presiding officer when feasible and shall notify other parties when seeking to continue hearings or other deadlines.

g. Disclosure of prohibited communications. A presiding officer who receives a prohibited ex parte communication during the pendency of a contested case must initially determine if the effect of the communication is so prejudicial that the presiding officer should be disqualified. If the presiding officer determines that disqualification is warranted, a copy of any prohibited written communication, all written responses to the communication, a written summary stating the substance of any prohibited oral or other communication not available in written form for disclosure, all responses made, and the identity of each person from whom the presiding officer received a prohibited ex parte communication shall be submitted for inclusion in the record under seal by protective order. If the presiding officer determines that disqualification is not warranted, such documents shall be submitted for inclusion in the record and served on all parties. Any party desiring to rebut the prohibited communication must be allowed the opportunity to do so upon written request filed within ten days after notice of the communication.

h. Disclosure by presiding officer. Promptly after receiving the communication or being assigned to serve as presiding officer at any stage in a contested case proceeding, a presiding officer shall disclose to all parties material factual information received through ex parte communication prior to such assignment unless the factual information has already been or shortly will be disclosed pursuant to Iowa Code section 17A.13(2) or through discovery. Factual information contained in an investigative report or similar document need not be separately disclosed by the presiding officer as long as such documents have been or will shortly be provided to the parties.

7.22(2) Disqualification of a presiding officer. Request for disqualification of a presiding officer must be filed in the form of a motion supported by an affidavit asserting an appropriate ground for disqualification. A substitute presiding officer may be appointed by the division of administrative hearings if the disqualified presiding officer is an administrative law judge. If the disqualified presiding officer is the director, the governor must appoint a substitute presiding officer.

a. Grounds for disqualification. A presiding officer or other person shall withdraw from participation in the making of any proposed or final decision in a contested case if that person:

- (1) Has a personal bias or prejudice concerning a party or a representative of a party;
- (2) Has personally investigated, prosecuted, or advocated in connection with that case the specific controversy underlying that case, another pending factually related contested case, or a pending factually related controversy that may culminate in a contested case involving the same parties;
- (3) Is subject to the authority, direction, or discretion of any person who has personally investigated, prosecuted, or advocated in connection with that contested case the specific controversy underlying that contested case or a pending factually related contested case or controversy involving the same parties;
- (4) Has acted as counsel to any person who is a private party to that proceeding within the past two years;
- (5) Has a personal financial interest in the outcome of the case or any other significant personal interest that could be substantially affected by the outcome of the case;

- (6) Has a spouse or relative within the third degree of relationship that:
 1. Is a party to the case or an officer, director, or trustee of a party to the case;
 2. Is a lawyer in the case;
 3. Is known to have an interest that could be substantially affected by the outcome of the case;or
4. Is likely to be a material witness in the case; or
- (7) Has any other legally sufficient cause to withdraw from participation in the decision making in that case.

b. Personally investigated. “Personally investigated” means taking affirmative steps to interview witnesses directly or to obtain documents or other information directly. The term “personally investigated” does not include general direction and supervision of assigned investigators, unsolicited receipt of information which is relayed to assigned investigators, review of another person’s investigative work product in the course of determining whether there is probable cause to initiate a proceeding, or exposure to factual information while performing other department functions, including fact gathering for purposes other than investigation of the matter which culminates in a contested case. Factual information relevant to the merits of a contested case received by a person who later serves as presiding officer in that case shall be disclosed if required by Iowa Code section 17A.17 and these rules.

c. Disqualification and the record. In a situation where a presiding officer or other person knows of information that might reasonably be deemed to be a basis for disqualification and decides voluntary withdrawal is unnecessary, that person shall submit the relevant information for the record by affidavit and shall provide for the record a statement of the reasons for the determination that withdrawal is unnecessary.

d. Motion asserting disqualification.

(1) If a party asserts disqualification on any appropriate ground, the party shall file a motion supported by an affidavit pursuant to Iowa Code section 17A.11. The motion must be filed as soon as practicable after the reason alleged in the motion becomes known to the party. If, during the course of the hearing, a party first becomes aware of evidence of bias or other grounds for disqualification, the party may move for disqualification but must establish the grounds by the introduction of evidence into the record.

(2) If the presiding officer determines that disqualification is appropriate, the presiding officer or other person shall withdraw. If the presiding officer determines that withdrawal is not required, the presiding officer shall enter an order to that effect. A party asserting disqualification may seek an interlocutory appeal and seek a stay as provided under this chapter.

This rule is intended to implement Iowa Code sections 17A.11 and 17A.17.

[ARC 8944C, IAB 2/19/25, effective 3/26/25]

701—7.23(421) Mailing to the last-known address or personal delivery of notices of assessment and refund denial letters.

7.23(1) *Failure by department to mail to last-known address or personally deliver.*

a. If the department fails to either mail a notice of assessment to the taxpayer’s last-known address or personally deliver the notice to the taxpayer, interest is waived for the month the failure occurs through the month of correct mailing or personal delivery.

b. In addition, if the department fails to either mail to the taxpayer’s last-known address or personally deliver to the taxpayer a notice of assessment or denial of a claim for refund or fails to mail or personally deliver a copy of the notice to the taxpayer’s authorized representative, if applicable, the time period to appeal the notice of assessment or a denial of a claim for refund is suspended until the notice or claim denial is correctly mailed or personally delivered or for a period not to exceed one year, whichever is the lesser period.

c. Collection activities, except in the case of a jeopardy assessment, shall be suspended and the statute of limitations for assessment and collection of the tax shall be tolled during the period in which interest is waived.

7.23(2) *Determination of last-known address.*

a. A taxpayer's last-known address for a particular tax type shall be one of the following most recently updated in the department's records:

- (1) The address provided in an application to register or receive a permit for a particular tax type;
- (2) The address used on the most recent filed and processed Iowa tax return of a particular tax type;
- (3) The address received by the department in a written, concise statement the taxpayer mailed to: Changes in Name or Address, Iowa Department of Revenue, P.O. Box 10465, Des Moines, Iowa 50306;
- (4) The address provided by the taxpayer in GovConnectIowa;
- (5) The address provided by the taxpayer in any correspondence to the department;
- (6) The address the department receives from a third-party skip tracing service; a public or private utility company in response to a subpoena issued pursuant to Iowa Code section 421.17(32); or a federal, state, or local agency.

b. While the determination of last-known address may differ by tax type, a notice of assessment or refund claim denial will be considered to be mailed to the last-known address if it is mailed to the taxpayer's last-known address used for another tax type.

7.23(3) *Mail or personal delivery to a taxpayer.* The following shall constitute personal delivery to a taxpayer:

- a. Personal service upon a taxpayer by any method deemed sufficient to constitute personal service of an original notice pursuant to the Iowa Rules of Civil Procedure.
- b. Providing a notice of assessment or refund claim denial to the taxpayer by electronic means based on the taxpayer's election to receive electronic communications in GovConnectIowa.
- c. Mailing to an address the department receives from a third-party skip tracing service; a public or private utility company in response to a subpoena issued pursuant to Iowa Code section 421.17(32); or a federal, state, or local agency.
- d. By any other method that is reasonably calculated to result in the taxpayer's actually receiving the notice, if the taxpayer actually receives the notice.

7.23(4) *Mail or personal delivery to authorized representatives.* The department may mail or personally deliver a copy of a notice to an authorized representative by one of the following methods:

- a. Mailing to the address used on the most recently filed and processed written authorization as described in rule 701—8.8(17A,22,421,422) for the taxpayer the authorized representative is representing, or the most recent address on file;
- b. In the case of fiduciary or inheritance tax matters, mailing to the address for the authorized representative contained on the most recently filed and processed return;
- c. By providing the notice electronically through GovConnectIowa or similar method of electronic service;
- d. By any method deemed sufficient to constitute personal service of an original notice pursuant to the Iowa Rules of Civil Procedure;
- e. By any other method that is reasonably calculated to result in the authorized representative's actually receiving a copy of the notice if the authorized representative actually receives a copy of the notice.

This rule is intended to implement Iowa Code section 421.60.

[ARC 8944C, IAB 2/19/25, effective 3/26/25]

701—7.24(441) Appeals of director's rejection of assessor appointment or reappointment.

7.24(1) *Written request for appeal.* Any assessor or conference board wishing to contest the director's rejection of the conference board's appointment of an assessor under 701—subrule 10.15(4)

or reappointment of an assessor under 701—subrule 103.16(3) shall file an appeal, in writing, within 30 days of the director's notice of decision. Any person who does not seek an appeal within 30 days of the director's notice shall be precluded from challenging the director's decision.

7.24(2) Procedures. Appeals will be governed by the procedures set forth in this rule together with the procedures set forth in the following rules:

- a. Subrules 7.3(2) and 7.3(3);
- b. Rule 701—7.7(17A);
- c. The introductory paragraph of rule 701—7.8(17A) and subrule 7.8(6);
- d. Subrules 7.11(1), 7.11(2), and 7.11(4);
- e. Rule 701—7.12(17A,421);
- f. Subrules 7.13(1) to 7.13(3);
- g. Rule 701—7.14(17A);
- h. Rule 701—7.15(17A);
- i. Rule 701—7.16(17A);
- j. Rule 701—7.17(17A);
- k. Subrule 7.18(1); subrules 7.18(3) through 7.18(7); subrule 7.18(8), except paragraph 7.18(8)“b” related to costs shall not apply; additionally, Iowa Code section 421.60 shall not apply; subrules 7.18(9) and 7.18(12);
- l. Rule 701—7.19(17A);
- m. Rule 701—7.20(17A);
- n. Rule 701—7.21(17A);
- o. Rule 701—7.22(17A); and
- p. Rule 701—8.8(17A,22,421,422).

7.24(3) Presiding officer. The director shall be the presiding officer in a contested case under this rule. The director may request that an administrative law judge assist and advise the director with any matters related to the contested case proceedings, including but not limited to ruling on any prehearing matters, presiding at the contested case hearing, and issuing orders and rulings.

7.24(4) Contents of the appeal. The appeal shall contain the following in separate numbered paragraphs:

- a. A statement of the department action giving rise to the appeal.
- b. The date of the department action giving rise to the appeal.
- c. Each error alleged to have been committed, listed as a separate paragraph. For each error listed, an explanation of the error and all relevant facts related to the error shall be provided.
- d. Reference to the particular statutes, rules, or agreement terms, if known.
- e. References to and copies of any documents or other evidence relevant to the appeal.
- f. Any other matters deemed relevant to the appeal.
- g. A statement setting forth the relief sought.
- h. The signature, mailing address, and telephone number of the person or that person's representative.

7.24(5) Burden of proof. The burden of proof is on the party challenging the director's decision under 701—subrule 10.15(4) or 103.16(3).

This rule is intended to implement Iowa Code section 441.6(3) and chapter 17A.

[ARC 8944C, IAB 2/19/25, effective 3/26/25]

701—7.25(441) Appeals and hearings regarding the director's intent to remove a member of the board of review.

7.25(1) Written request for hearing. A member of the board of review who has received a notice of intent to remove from the director and who wishes to contest the removal shall file a written request for a hearing within 30 days after the receipt of the notice of the director's intent to remove the member. Any person who does not seek a hearing within 30 days of receipt of the notice of the director's intent to remove shall be precluded from challenging the removal.

7.25(2) Procedures. Hearings will be governed by the procedures set forth in this rule together with the procedures set forth in the following rules:

- a. The introductory paragraph of rule 701—7.7(17A), excluding the first sentence of the introductory paragraph of 701—7.7(17A); and subrule 7.8(6);
- b. Subrule 7.8(1);
- c. 701—7.9(17A);
- d. Subrules 7.11(1) to 7.11(4);
- e. Rule 701—7.12(17A,421);
- f. Rule 701—7.13(17A);
- g. Rule 701—7.14(17A);
- h. Rule 701—7.15(17A);
- i. Subrule 7.18(1); 7.18(3) through 7.18(7); subrule 7.18(8), except paragraph 7.18(8)“b” related to costs shall not apply; additionally, Iowa Code section 421.60 shall not apply; subrules 7.18(9), and 7.18(12);
- j. Rule 701—7.17(17A);
- k. Rule 701—7.18(17A);
- l. Rule 701—7.19(17A);
- m. Rule 701—7.20(17A); and
- n. Rule 701—7.21(17A).

7.25(3) Presiding officer. The director shall be the presiding officer in a contested case under this rule. The director may request that an administrative law judge assist and advise the director with any matters related to the contested case proceedings, including but not limited to ruling on any prehearing matters, presiding at the contested case hearing, and issuing orders and rulings.

7.25(4) Contents of the appeal. The appeal shall contain the following in separate numbered paragraphs:

- a. A statement of the department action giving rise to the appeal.
- b. The date of the department action giving rise to the appeal.
- c. Each error alleged to have been committed, listed as a separate paragraph. For each error listed, an explanation of the error and all relevant facts related to the error shall be provided.
- d. Reference to the particular statutes, rules, or agreement terms, if known.
- e. References to and copies of any documents or other evidence relevant to the appeal.
- f. Any other matters deemed relevant to the appeal.
- g. A statement setting forth the relief sought.
- h. The signature, mailing address, and telephone number of the person or that person’s representative.

7.25(5) Burden of proof. The burden of proof is on the party challenging the director’s intent to remove a board member.

This rule is intended to implement Iowa Code section 441.32(2) “e” and chapter 17A.

[ARC 8944C, IAB 2/19/25, effective 3/26/25]

701—7.26(17A) License and permit denials and revocations.

7.26(1) Specified license or permit denial and revocation processes. Procedures related to alcohol and lottery license denials and revocations are contained in 701—Chapters 1000 and 1102. Procedures related to sales or use tax permit revocations are contained in 701—Chapter 201. For all other license and permit denials, this rule applies.

7.26(2) Denial of license or permit; refusal to renew license or permit.

- a. *Written notice in general.* When the department is required by constitution or statute to provide notice and an opportunity for an evidentiary hearing prior to the refusal or denial of a license, the department will serve notice of intent to deny or refuse the license by restricted certified mail or by personal service as in a civil action. The notice will contain a statement of facts or conduct and the provisions of law that warrant the denial of the license or the refusal to renew a license. The notice

will provide the licensee or applicant with 30 days to request a hearing and information about how to contact the department to make such a request.

b. Requesting a hearing. If a hearing is requested, the matter will be transferred to the administrative hearings office unless retained by the director.

c. Notice of hearing. A notice of hearing issued as described in rule 701—7.15(17A) upon the licensee or applicant.

d. Licensee opportunity to file a petition. If the licensee so desires, the licensee may file a petition as provided in subrule 7.26(4) with the presiding officer within 30 days prior to the hearing. The department may, in its discretion, file an answer to a petition filed by the licensee prior to the hearing. Thereafter, rule 701—7.18(17A) governing contested case proceedings shall apply.

e. Treatment of existing license while matter is pending. When a licensee has made timely and sufficient application for the renewal of a license or a new license with reference to any activity of a continuing nature, the existing license does not expire until the application has been finally determined by the department, and in the case the application is denied or the terms of the new license limited, until the last date for seeking judicial review of the department's order or a later date fixed by order of the department or the reviewing court.

7.26(3) Revocation of license.

a. Written notice in general. The department will not revoke, suspend, annul or withdraw any license until written notice is served by restricted certified mail or by personal service as in a civil case. The notice will provide the licensee with the 30 days to request a hearing and information about how to contact the department to make such a request. If a hearing is requested, the matter will be transferred to the division of administrative hearings unless retained by the director. A notice of hearing will be issued by the presiding officer as described in rule 701—7.15(17A) The licensee whose license is to be revoked, suspended, annulled, or withdrawn, will be given an opportunity to show at an evidentiary hearing conducted pursuant to rule 701—7.18(17A) compliance with all lawful requirements for the retention of the license.

b. Contents of notice. In addition to the requirements of rule 701—7.15(17A), the notice shall contain a statement of facts or conduct and the provisions of law that warrant the revocation, suspension, annulment, or withdrawal of the license.

c. Licensee opportunity to file petition. A licensee whose license may be revoked, suspended, annulled, or withdrawn may file a petition as provided in subrule 7.26(4) with the department prior to the hearing. The petition should be filed at the address provided on the notice to revoke, suspend, annul, or withdraw. The department may, in its discretion, file an answer to a petition filed by the licensee prior to the hearing. Thereafter, rule 701—7.18(17A) governing contested case proceedings shall apply.

d. Emergency proceedings. Notwithstanding paragraph 7.26(3)“a,” if the department finds that public health, safety, or welfare imperatively requires emergency action and the department incorporates a finding to that effect in an order to the licensee, summary suspension of a license shall be ordered pending proceedings for revocation as provided herein. These proceedings shall be promptly instituted and determined. When a summary suspension as provided herein is ordered, a notice of the time, place and nature of the evidentiary hearing shall be attached to the order.

7.26(4) Petition.

a. When a person desires to file a petition as provided in subrules 7.26(2) and 7.26(3), the petition to be filed shall contain a caption in the following form:

BEFORE THE DEPARTMENT OF REVENUE
HOOVER STATE OFFICE BUILDING
DES MOINES, IOWA

IN THE MATTER OF	*	PETITION
State taxpayer's name and address, and	*	Docket No.
type of license)	*	(filled in by Department)

- b.* The petition shall substantially state in separate numbered paragraphs the following:
- (1) The full name and address of the petitioner;
 - (2) Reference to the type of license and the relevant statutory authority;
 - (3) Clear, concise and complete statements of all relevant facts showing why petitioner's license should not be revoked, refused, or denied;
 - (4) Whether a similar license has previously been issued to or held by petitioner or revoked and if revoked the reasons therefor; and
 - (5) The signature of the petitioner or petitioner's representative, the address of petitioner and of the petitioner's representative, and the telephone number of petitioner or petitioner's representative.

This rule is intended to implement Iowa Code section 17A.18.

[ARC 8944C, IAB 2/19/25, effective 3/26/25]

[Filed 7/1/75]

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CHAPTER 11
TAX ADMINISTRATION
[Prior to 12/17/86, Revenue Department[730]]

Chapter rescission date pursuant to Iowa Code section 17A.7: 3/26/30

701—11.1(421) Definitions. For purposes of this chapter:

“*Department*” means the Iowa department of revenue.

“*Director*” means the director of revenue or the director’s designee.

“*Taxpayer*” includes any person subject to the provisions of a tax or charge administered by the department whether acting on the person’s own behalf or as an agent or fiduciary.

This rule is intended to implement Iowa Code chapter 421.

[ARC 8947C, IAB 2/19/25, effective 3/26/25]

701—11.2(421) Scope.

11.2(1) Except as otherwise provided in this chapter, this chapter provides certain rules related to the department’s administration of the following taxes:

- a. Sales and use taxes and local option taxes under Iowa Code chapters 423 and 423B.
- b. Fee for new registration under Iowa Code section 321.105A.
- c. Hotel and motel tax under Iowa Code chapter 423A.
- d. Automobile rental excise tax under Iowa Code chapter 423C.
- e. Equipment tax under Iowa Code chapter 423D.
- f. Water service excise tax under Iowa Code chapter 423G.
- g. Motor fuel, special fuel, and electric fuel taxes under Iowa Code chapter 452A.
- h. Cigarette and tobacco taxes under Iowa Code chapter 453A.

11.2(2) The tax administration rules described in this chapter are not intended to be comprehensive. The administrative code chapters for each relevant tax may contain additional tax administration rules.

This rule is intended to implement Iowa Code chapter 421.

[ARC 8947C, IAB 2/19/25, effective 3/26/25]

701—11.3(321,421,423,452A,453A) Taxpayer records.

11.3(1) *Records required.* Every taxpayer shall keep and preserve records. The records must include the normal books of account ordinarily maintained by a person engaged in the activity in question including but not limited to all bills, receipts, invoices, cash register tapes, or other documents of original entry supporting the entries in the books of account as well as all schedules or working papers used in connection with the preparation of tax returns or reports. The records must be made available for examination upon request by the director.

11.3(2) *Automatic data processing records.* Automatic data processing (ADP) is defined in this rule as including electronic data processing (EDP).

a. An ADP tax accounting system must have built into its program a method of producing visible and legible records that will provide the necessary information for verification of the taxpayer’s tax liability.

b. ADP records must provide an opportunity to trace any transaction back to the original source or forward to a final total. If detailed printouts are not made of transactions at the time they are processed, then the system must have the ability to reconstruct these transactions.

c. A general ledger with source references will be produced to coincide with financial reports of tax reporting periods. In cases where subsidiary ledgers are used to support the general ledger accounts, the subsidiary ledgers should also be produced periodically.

d. Supporting documents and audit trail. The audit trail should be designed so that the details underlying the summary accounting data may be identified and made available to the director upon request. The system should be designed so that the supporting documents are readily available. An

audit trail is defined as the condition of having sufficient documentary evidence to trace an item from a source to a financial statement or tax return or report; or the reverse; that is, to have an auditable system.

e. Program documentation. A description of the ADP portion of the accounting program should be available. The statements and illustrations as to the scope of operations should be sufficiently detailed to indicate:

- (1) The application being performed.
- (2) The procedure employed in each application, which, for example, might be supported by flow charts, block diagrams or other satisfactory description of the input or output procedures.
- (3) The controls used to ensure accurate and reliable processing. Program and system changes, together with their effective dates, should be noted in order to preserve an accurate chronological record.

f. Storage of ADP output will be in appropriate facilities to ensure preservation and readability of output.

11.3(3) *Electronic data interchange or EDI technology.*

a. Definitions. The following definitions are applicable to this subrule:

“Database management system” means a software system that controls, relates, retrieves, and provides accessibility to data stored in a database.

“Electronic data interchange” or *“EDI technology”* means the computer-to-computer exchange of business transactions in a standardized, structured electronic format.

“Hard copy” means any documents, records, reports, or other data printed on paper.

“Machine-sensible record” means a collection of related information in an electronic format. Machine-sensible records do not include hard-copy records that are created or recorded on paper or stored in or by an imaging system such as microfilm, microfiche, or storage-only imaging systems.

“Storage-only imaging system” means a system of computer hardware and software that provides for the storage, retention, and retrieval of documents originally created on paper. It does not include any system, or part of a system, that manipulates or processes any information or data contained on the document in any manner other than to reproduce the document in hard copy or as an optical image.

b. This subrule prescribes requirements imposed on taxpayers for the maintenance and retention of books, records, and other sources of information under Iowa law. It is also the purpose of this subrule to address these requirements where all or part of the taxpayer’s records are received, created, maintained, or generated through various computer, electronic, and imaging processes and systems. A taxpayer must maintain all records that are necessary for determination of the correct tax liability as set forth in this subrule. All required records must be made available on request by the department. If a taxpayer retains records required to be retained under this subrule in both machine-sensible and hard-copy formats, the taxpayer must make the records available to the department in machine-sensible format upon request of the department. Nothing in this subrule will be construed to prohibit a taxpayer from demonstrating tax compliance with traditional hard-copy documents or reproductions thereof, in whole or in part, whether or not the taxpayer also has retained or has the capability to retain records on electronic or other storage media in accordance with this subrule. However, this will not relieve a taxpayer of the obligation to comply with the requirement to make records available to the department.

c. Recordkeeping requirements—machine-sensible records. A taxpayer that maintains and retains books, records, and other sources of information in the form of machine-sensible records must comply with the following:

(1) General requirements. A taxpayer must comply with the following general requirements regarding the retention of machine-sensible records:

1. Machine-sensible records used to establish tax compliance must contain sufficient transaction-level detail information so that the details underlying the machine-sensible records can be identified and made available to the department upon request. A taxpayer has discretion to discard duplicate records and redundant information provided its responsibilities under this rule are met.

2. At the time of an examination, the retained records must be capable of being retrieved and converted to a standard record format. The term “standard record format” does not mean that every taxpayer must keep records in an identical manner. Instead, it requires that if a taxpayer utilizes a code system to identify elements of information in each record when creating and maintaining records, the taxpayer is required to maintain a record of the meaning of each code and any code changes so the department may effectively review the taxpayer’s records.

3. Taxpayers are not required to construct machine-sensible records other than those created in the ordinary course of business. A taxpayer that does not create the electronic equivalent of a traditional paper document in the ordinary course of business is not required to construct a traditional paper document for tax purposes.

(2) Electronic data interchange requirements. A taxpayer must comply with the following requirements for records received through electronic data interchange:

1. Where a taxpayer uses an electronic data interchange process and technology, the level of record detail, in combination with other records related to the transactions, must be equivalent to that contained in an acceptable paper record. For example, the retained records should contain the following minimal information: vendor name, invoice date, product description, quantity purchased, price, amount of tax, indication of tax status, and shipping details. Codes may be used to identify some or all of the data elements, provided that the taxpayer provides a method which allows the department to interpret the coded information.

2. The taxpayer may capture the information necessary to satisfy the requirements set forth in the preceding paragraph at any level within the accounting system and need not retain the original EDI transaction records provided that the audit trail, authenticity, and integrity of the retained records can be established. For example, a taxpayer using electronic data interchange technology receives electronic invoices from its suppliers. The taxpayer decides to retain the invoice data from completed and verified EDI transactions in its accounts payable system rather than to retain the EDI transactions themselves. Since neither the EDI transaction nor the accounts payable system captures information from the invoice pertaining to product description and vendor name (i.e., they contain only codes for that information), the taxpayer also retains the other records such as its vendor master file and product code description lists and makes them available to the department. In this example, the taxpayer need not retain its original EDI transaction for tax purposes.

(3) Electronic data processing systems requirements. The requirements for an electronic data processing accounting system should be similar to that of a manual accounting system, in that an adequately designed accounting system should incorporate methods and records that will satisfy the requirements of this rule. In addition, pursuant to Iowa law, the department must have access to the taxpayer’s EDI processing, accounting, or other systems for the purposes of verifying or evaluating the integrity and reliability of those systems to provide accurate and complete records.

(4) Business process information. To verify the accuracy of the records being retained, the taxpayer must comply with the following:

1. Upon the request of the department, the taxpayer shall provide a description of the business process that created the retained records. The description must include the relationship between the records and the tax documents prepared by the taxpayer and the measures employed to ensure the integrity of the records.

2. The taxpayer must be capable of demonstrating the following:

- The functions being performed as they relate to the flow of data through the system;
- The internal controls used to ensure accurate and reliable processing; and
- The internal controls used to prevent unauthorized addition to, alteration of, or deletion of retained records.

3. The following specific documentation is required for machine-sensible records retained pursuant to this rule:

- Record formats or layouts;

- Field definitions (including a record of any changes in the system or codes with the meaning of all codes used to represent information);
- File descriptions (e.g., data set name); and
- Detailed charts of accounts and account descriptions.

d. Record maintenance requirements. The department recommends but does not require that taxpayers refer to the National Archives and Record Administration's (NARA) standards for guidance on the maintenance and storage of electronic records such as the labeling of records, the location and security of the storage environment, the creation of backup copies, and the use of periodic testing to confirm the continued integrity of the records. The NARA standards may be found at 36 Code of Federal Regulations, Part 1234, November 2, 2009, Edition. The taxpayer's computer hardware and software must accommodate the extraction and conversion of retained machine-sensible records.

e. Access to machine-sensible records. If a taxpayer retains records required to be retained under this rule in both machine-sensible and hard-copy formats, the taxpayer must make the records available to the department in machine-sensible format upon the request of the department.

(1) The manner in which the department is provided access to machine-sensible records may be satisfied through a variety of means that must take into account a taxpayer's facts and circumstances through consultation with the taxpayer.

(2) Access will be provided in one or more of the following manners:

1. The taxpayer may arrange to provide the department with the hardware, software, and personnel resources to access the machine-sensible records.

2. The taxpayer may arrange for a third party to provide the hardware, software, and personnel resources necessary to access the machine-sensible records.

3. The taxpayer may convert the machine-sensible records to a standard record format specified by the department, including copies of files, on a magnetic medium that is agreed to by the department.

4. The taxpayer and the department may agree on other means of providing access to the machine-sensible records.

f. Taxpayer's responsibility and discretionary authority. In conjunction with meeting the requirements of paragraph 11.3(3) "c," a taxpayer may create files solely for the use of the department. For example, if a database management system is used, it is consistent with this subrule for the taxpayer to create and retain a file that contains the transaction-level detail from the database management system and that meets the requirements of paragraph 11.3(3) "c." The taxpayer should document the process that created the separate file to show the relationship between that file and the original records. A taxpayer may contract with a third party to provide custodial or management services of the records. Such a contract will not relieve the taxpayer of its responsibilities under this rule.

g. Alternative storage media. For purposes of storage and retention, taxpayers may convert hard-copy documents received or produced in the normal course of business and required to be retained under this rule to microfilm, microfiche, or other storage-only imaging systems and may discard the original hard-copy documents, provided the rules governing alternative storage media are met.

h. Microfilm, microfiche, and other storage-only imaging systems. These shall meet the following requirements:

(1) Documentation establishing the procedures for converting the hard-copy documents to microfilm, microfiche, or other storage-only imaging system must be maintained and made available upon request. Such documentation shall, at a minimum, contain sufficient description to allow an original document to be followed through the conversion system as well as internal procedures established for inspection and quality assurance.

(2) Procedures must be established for the effective identification, processing, storage, and preservation of the stored documents and for making them available for the period they are required to be retained.

(3) Upon request by the department, a taxpayer must provide facilities and equipment for reading, locating, and reproducing any documents maintained on microfilm, microfiche, or other storage-only imaging system.

(4) When displayed on such equipment or reproduced on paper, the documents must exhibit a high degree of legibility and readability. For this purpose, legibility is defined as the quality of a letter or numeral that enables the observer to identify it positively and quickly to the exclusion of all other letters or numerals. Readability is defined as the quality of a group of letters or numerals being recognizable as words or complete numbers.

(5) All data stored on microfilm, microfiche, or other storage-only imaging systems must be maintained and arranged in a manner that permits the location of any particular record.

(6) There is no substantial evidence that the microfilm, microfiche, or other storage-only imaging system lacks authenticity or integrity.

i. Effect on hard-copy recordkeeping requirements. Except as otherwise provided, the provisions of this subrule do not relieve taxpayers of the responsibility to retain hard-copy records that are created or received in the ordinary course of business as required by existing law and rules. Hard-copy records may be retained on alternative storage media as indicated in this subrule.

(1) If hard-copy records are not produced or received in the ordinary course of transacting business (e.g., when the taxpayer uses electronic data interchange technology), hard-copy records need not be created.

(2) Hard-copy records generated at the time of a transaction using a credit or debit card must be retained unless all the details necessary to determine correct tax liability relating to the transaction are subsequently received and retained by the taxpayer in accordance with this rule.

(3) Computer printouts that are created for validation, control, or other temporary purposes need not be retained.

(4) Nothing in this rule will prevent the department from requesting hard-copy printouts in lieu of retained machine-sensible records at the time of examination.

11.3(4) *Preservation of records.*

a. The records required in this rule shall be preserved, at a minimum, for the length of time that the records may be relevant to the department's determination of tax liability for any tax year, and shall be open for examination by the department during this period of time.

b. If a tax liability has been assessed and an appeal is pending to the department, district court, or an appellate court, the records described in this rule which relate to the period covered by the assessment shall be preserved until the final disposition of the appeal.

c. If the requirements of this rule are not met, the records will be considered inadequate.

This rule is intended to implement Iowa Code sections 321.105A, 421.17, 423.41, 452A.10, 453A.15, 453A.18, 453A.19, and 453A.24.

[ARC 8947C, IAB 2/19/25, effective 3/26/25]

701—11.4(421,423,452A,453A) Audit of records.

11.4(1) *In general.* The department has the right and duty to examine or cause to be examined the books, papers, records, memoranda or documents of a taxpayer for the purpose of verifying the correctness of a return or report filed or determining the tax liability of any taxpayer. The right to examine records includes but is not limited to the right to examine copies of the taxpayer's state and federal income tax returns.

11.4(2) *Delegation of authority.* Pursuant to statutory authority, the director delegates to department staff the power to examine reports, returns, and records; make audits; determine the correct amount of tax, penalty, interest, and fines due; and take all actions authorized to collect the same, subject to review by or appeal to the director.

11.4(3) *Audit costs.*

a. In the case of fuel taxes under Iowa Code chapter 452A, the costs incurred in examining the records of a taxpayer are at the taxpayer's expense when the records are kept at an out-of-state

location. Costs will include meals, lodging, and travel expenses but will not include salaries of department personnel.

b. In the case of cigarette and tobacco taxes under Iowa Code chapter 453A, when it is determined upon audit that any person dealing in cigarettes owes additional tax, the costs of the audit are assessed against such person as additional penalty.

This rule is intended to implement Iowa Code sections 421.17, 423.37, 452A.43, 452A.62, 452A.76, and 453A.30.

[ARC 8947C, IAB 2/19/25, effective 3/26/25]

701—11.5(421) Time and place of taxpayer interviews. This rule governs taxpayer interviews related to all taxes and charges administered by the department. If a taxpayer is selected for an interview, the time and place of the interview is to be fixed by an employee of the department and employees of the department are to endeavor to schedule a time and place that is reasonable under the circumstances.

11.5(1) *Time of taxpayer interviews.* The department will schedule the day(s) for a taxpayer interview during a normally scheduled workday(s) of the department during the department's normal business hours. The department will schedule taxpayer interviews throughout the year without regard to seasonal fluctuations in the business of particular taxpayers or their representatives. The department will, however, work with taxpayers or their representatives to try to minimize any adverse effects in scheduling the date and time of a taxpayer interview.

11.5(2) *Type of taxpayer interview.*

a. The department will determine whether a taxpayer interview will be an office interview (i.e., an interview conducted at a department office) or a field interview (i.e., an interview conducted at the taxpayer's place of business or residence, or some other location that is not a department office) based on which form of interview will be more conducive to effective and efficient tax administration.

b. The department may grant a request to hold an office interview at another location.

11.5(3) *Place of taxpayer interview.* The department will make an initial determination of the place for an interview based on the address shown on the return for the tax period to be examined. Requests by taxpayers to transfer the place of interview will be resolved on a case-by-case basis using the criteria set forth in paragraph 11.5(3) "c."

a. Office taxpayer interviews. An office interview of an individual or sole proprietorship generally is based on the residence of the individual taxpayer. An office interview of a taxpayer that is a business or other legal entity generally is based on the location where the taxpayer's original books, records, and source documents are maintained.

b. Field taxpayer interviews. A field interview generally will take place at the location in this state where the taxpayer's original books, records, and source documents pertinent to the interview are maintained. In the case of a business, this usually will be the taxpayer's principal place of business.

c. Requests by taxpayers to change place of interview. The department will consider, on a case-by-case basis, written requests by taxpayers or their representatives to change the place that the department has set for an interview. In considering these requests, the department will take into account the following factors:

- (1) The location of the taxpayer's current residence;
- (2) The location of the taxpayer's current principal place of business;
- (3) The location where the taxpayer's books, records, and source documents are maintained;
- (4) The location at which the department can perform the interview most efficiently;
- (5) The department resources available at the location to which the taxpayer has requested a transfer; and
- (6) Other factors that indicate that conducting the interview at a particular location could pose undue inconvenience to the taxpayer.

d. Granting of requests to change place of interview. A request by a taxpayer to transfer the place of interview generally will be granted under the following circumstances:

(1) In the case of a taxpayer that is a small business, if an interview is scheduled at the taxpayer's place of business and the taxpayer can demonstrate in writing that conducting the interview at the place of business would essentially require the business to close or would unduly disrupt business operations, the department will change the place of interview.

(2) If a taxpayer does not reside at the residence where an interview has been scheduled, the department will agree to transfer the examination to the taxpayer's current residence.

(3) If the taxpayer's books, records, and source documents are maintained at a location in this state other than the location where the interview has been scheduled, the department will agree to transfer the interview to the location where the taxpayer's books, records, and source documents are maintained.

e. Other factors that affect the location of an interview include:

(1) The location of the place of business of a taxpayer's representative generally will not be considered in determining the place for an interview. However, the department in its sole discretion may determine, based on the factors described in paragraph 11.5(3)"c," to transfer the place of interview to the representative's office.

(2) If any applicable period of limitations of assessment and collection provided in the Iowa Code will expire within 13 months from the date of a taxpayer's request to transfer the place of interview, the department may require, as a condition to the transfer, that the taxpayer agree in writing to extend the limitations period up to one year.

(3) The department is not required to transfer an interview to an office that does not have adequate resources to conduct the interview.

(4) Notwithstanding any other provision of this rule, employees of the department may decline to conduct an interview at a particular location if it appears that the possibility of physical danger may exist at that location. In these circumstances, the department may transfer an interview to a department office and take any other steps reasonably necessary to protect its employees.

(5) Nothing in this rule shall be interpreted as precluding the department from initiating the transfer of an interview if the transfer would promote the effective and efficient conduct of the interview. Should a taxpayer request that such a transfer not be made, the department will consider the request according to the principles and criteria set forth in paragraph 11.5(3)"c."

(6) Regardless of where an interview takes place, the department may visit the taxpayer's place of business or residence to establish facts that can only be established by direct visit, such as inventory or asset verification. The department generally will visit for these purposes on a normal workday of the department during the department's normal business hours.

11.5(4) *Audio recordings of taxpayer interviews.*

a. The department and a taxpayer are permitted to make an audio recording of any interview of the taxpayer by the department relating to the determination or collection of any tax. A recording of the interview by a taxpayer is at the taxpayer's own expense and must be with the taxpayer's own equipment.

b. Notification of intent to make audio recordings must be addressed by the taxpayer to the department employee who is conducting the interview, or by the department to the taxpayer, and must be received before the day of the interview. If adequate advance notice is not given, the party who failed to receive timely notification may, in their discretion, proceed with the interview or schedule a new date for the interview.

c. If the interview is recorded by the department, the taxpayer or their representative may, upon request, receive a transcript or copy of the recording. Such requests must be addressed to the employee conducting the interview and must be received by the department no later than 30 calendar days after the date of the recording. The taxpayer must pay the costs of duplication or transcription.

d. At the beginning of the recording of an interview, the department employee conducting the interview must state the employee's name, the date, the time, the place, and the purpose of the interview. At the end of the interview, the department employee will state that the interview has been completed and that the recording has ended.

e. When written records are presented or discussed during the interview being recorded, they must be described in sufficient detail to make the audio recording a meaningful record when matched with the other documentation contained in the case file.

This rule is intended to implement Iowa Code section 421.60.

[ARC 8947C, IAB 2/19/25, effective 3/26/25]

701—11.6(421) Adjustments.

11.6(1) *Notice of proposed adjustments.*

a. An employee of the department designated by the director to examine returns and make audits who discovers discrepancies or omissions in returns or who discovers that no return was filed when one was due is authorized to notify the person of this discovery by mail or electronically in accordance with rule 701—8.6(421). This notice is not an assessment. It informs the person of the amount that would be due if the proposed adjustments are finalized.

b. Right of person upon receipt of notice of adjustment. A person who has received notice of a proposed adjustment in connection with a return may do either of the following:

(1) Pay the additional amount stated to be due, if any. If payment is made and the person wishes to contest the matter, the person should then file a claim for refund. Payment is not required until an assessment is made, although interest will continue to accrue if payment is not made.

(2) If no payment is made, the person may discuss with the employee who notified the person of the proposed adjustments all matters of fact and law that may be relevant to the situation. This person may also ask for a conference with the Alcohol and Tax Compliance Division. Documents and records supporting the person's position may be required.

c. If after following the procedures outlined in this subrule, no agreement is reached and the person does not pay the amount determined to be correct, if any, or if the department in its discretion does not send notice of the proposed adjustments, the department will send a notice of assessment or a denial of a refund claim which initiates the appeal period.

11.6(2) *Notice of assessment.*

a. A notice of assessment will be issued in accordance with the Iowa Code, within the time period prescribed by the Iowa Code, and will be sent by mail or electronically in accordance with rule 701—8.6(421).

b. If the notice of assessment is timely appealed in accordance with 701—Chapter 7, proceedings to collect the tax will not be commenced until the appeal is ultimately determined unless the department has reason to believe that a delay caused by the appeal proceedings will result in an irrevocable loss of tax ultimately found to be due and owing the state of Iowa.

11.6(3) *Supplemental assessments.* The department may, at any time within the applicable statute of limitations period for examining a tax return, issue a supplemental assessment whenever it is ascertained that any prior assessment or refund adjustment was inaccurate. The department may also, at any time within the applicable statute of limitations period for examining a tax return, issue an assessment whenever it is ascertained that any prior refund was issued in error.

11.6(4) *Denial of a refund claim.* A denial of a refund claim will be issued in accordance with the Iowa Code. The department may issue a denial of a refund claim in whole or in part at any time if the department determines a claim for refund is untimely or without merit.

11.6(5) *Effect of resolved assessments or refund adjustments.* If an assessment or refund adjustment is appealed in accordance with 701—Chapter 7 and is resolved, whether by informal proceedings or by adjudication, the department and the taxpayer are precluded from making a supplemental assessment or refund adjustment concerning the same issue involved in the appeal for the same tax period unless there is a showing of mathematical or clerical error or a showing of fraud or misrepresentation.

This rule is intended to implement Iowa Code section 421.60.

[ARC 8947C, IAB 2/19/25, effective 3/26/25]

701—11.7(422,453B) Jeopardy assessments.

11.7(1) *Generally.* This rule governs jeopardy assessments for all taxes and charges administered by the department. A jeopardy assessment may be made where the director believes for any reason that assessment or collection of the tax will be jeopardized by delay. In addition, all assessments made pursuant to Iowa Code chapter 453B are jeopardy assessments. The department is authorized to estimate the applicable tax base and the tax upon available information, add penalty and interest, and demand immediate payment. Proceedings to enforce the payment of the assessment by seizure or sale of any property of the taxpayer may be instituted immediately.

11.7(2) *Request for bond.*

a. In the event a taxpayer seeks to post a bond in lieu of summary collection of a jeopardy assessment, pending final determination of the amount of tax legally due, the taxpayer must file a Jeopardy Assessment Bond Request Form, available on the department's website, with the clerk of the legal services division for the department. The department will accept or reject the bond request, in writing, within ten days. If the department does not respond within ten days, the bond request is deemed rejected. The department is not required to accept bond requests. If the department accepts the bond request, the clerk of the legal services division for the department shall be notified. The approval is conditioned upon the taxpayer's posting the bond in accordance with this rule.

b. Bond requests may be made any time after a timely appeal of the jeopardy assessment has been filed with the department in accordance with 701—Chapter 7, except that any bond request whereby the taxpayer seeks to postpone a scheduled sale of assets seized by or on behalf of the department must be filed with the clerk of the legal services division for the department no later than ten days from the date on which notice of the sale was mailed to, or otherwise served upon, the taxpayer. Portions of an assessment that are undisputed must be paid in full at the time a bond request is filed.

11.7(3) *Posting of bond.* If the department accepts the bond request, the taxpayer shall post the bond within 15 days from the date the taxpayer was notified of the acceptance by the department. If the taxpayer fails to post the bond by the deadline, the bond request is deemed rejected and no bond will be allowed.

11.7(4) *Type of bond.*

a. The bond shall be payable to the department for the use of the state of Iowa and shall be conditioned upon the full payment of the tax, penalty, interest, or fees that are found to be due which remain unpaid upon the resolution of the contested case proceedings up to the amount of the bond.

b. A personal bond, without a surety, is only permitted if the taxpayer posts with the clerk of the legal services division for the department, cash, a cashier's check, a certificate of deposit, or other marketable securities which are approved by the department with a readily ascertainable value which is equal in value to the total amount of the bond required. If a surety bond is posted, the surety on the bond may be either personal or corporate. The provisions of Iowa Code chapter 636 relating to personal and corporate sureties shall govern to the extent not inconsistent with the provisions of this subrule.

11.7(5) *Form of surety bond.* The surety bond posted shall be in substantially the following form:

BEFORE THE IOWA STATE DEPARTMENT OF REVENUE	
HOOVER STATE OFFICE BUILDING	
DES MOINES, IOWA	
IN THE MATTER OF	*
	*
(Taxpayer's Name, Address and	*
designate proceeding, e.g.,	*
income, sales, etc.)	*
	*
	*

SURETY BOND

DOCKET NO.

KNOW ALL PERSONS BY THESE PRESENTS:

That we _____ (taxpayer) as principal, and _____ (surety), as surety, of the county of _____, and State of Iowa, are held and firmly bound unto the Iowa Department of Revenue for the use of the State of Iowa, in the sum of \$ _____ dollars, lawful money of the United States, for the payment of which sum we jointly and severally bind ourselves, our heirs, devisees, successors and assigns firmly by these presents. The condition of the foregoing obligations are, that, whereas the above-named principal has protested an assessment of tax, penalty, interest, or fees or any combination of them, made by the Iowa Department of Revenue, now if the principal _____ shall promptly pay the amount of the assessed tax, penalty, interest or fees found to be due upon the resolution of the contested case proceedings, then this bond shall be void, otherwise to remain in full force and effect.

Dated this _____ day of _____, _____.

Principal

Surety

Surety

(corporate acknowledgment if surety is a corporation)

AFFIDAVIT OF PERSONAL SURETY

STATE OF IOWA)
COUNTY OF) ss

I hereby swear or affirm that I am a resident of Iowa and am worth beyond my debts the amount set opposite my signature below in the column entitled, "Worth Beyond Debts," and that I have property in the State of Iowa, liable to execution equal to the amount set opposite my signature in the column entitled "Property in Iowa Liable to Execution."

Signature	Worth Beyond Debts	Property in Iowa Liable to Execution
_____ Surety (type name)	\$ _____	\$ _____
_____ Surety (type name)	\$ _____	\$ _____

Subscribed and sworn to before me the undersigned Notary Public this _____ day of _____, _____.

(Seal)

Notary Public in and
for the State of Iowa

11.7(6) *Duration of bond.* The bond shall remain in full force and effect until the conditions of the bond have been fulfilled or until the bond is otherwise exonerated as provided by law.

11.7(7) *Exoneration of bond.* Upon conclusion of the contested case administrative proceedings, the bond shall be exonerated by the department when any of the following events occur: upon full payment of the tax, penalty, interest, costs or fees found to be due; upon filing a bond for the purposes of judicial review which bond is sufficient to secure the unpaid tax penalty, interest, costs and fees; or if no additional tax, penalty, interest, costs or fees are found to be due that have not been previously paid, upon entry of a final unappealable order which resolves the underlying appeal.

This rule is intended to implement Iowa Code sections 422.30 and 453B.9.

[ARC 8947C, IAB 2/19/25, effective 3/26/25; ARC 0321D, IAB 5/27/26, effective 7/1/26]

701—11.8(421,422) Application of payments to fees, penalty, interest, and then tax due. This rule governs the application of payments for all taxes and charges administered by the department.

11.8(1) *Reapplication of prior payments.* The department will not reapply prior payments made on or before the due date of the original return by the taxpayer to penalty or interest determined to be due after the date of those prior payments. However, the department will apply payments to penalty and interest which were due at the time the payment was made.

Example (a) — Delinquent Return

- a. Tax due is \$1,000.
- b. Return filed two months late.
- c. \$1,000 paid with the return.
- d. Assume 0.7% monthly interest for purpose of example.
- e. The department bills the additional tax in the third month after the due date. The taxpayer pays the assessment in the third month.

The computation of fees, penalty, interest, and tax is shown below:

Tax	\$1,000.00
Penalty	100.00 (5% failure to file penalty and 5% failure to timely pay penalty)
Interest	14.00 (2 months interest)
Subtotal	\$1,114.00
Less payment	(1,000.00)
Remaining tax due	\$ 114.00
Interest	.80 (1 month interest)
Total due	\$ 114.80

Two years after the due date, the Internal Revenue Service conducts an audit and increases the taxpayer's taxable income. The department redetermines the taxpayer's liability 26 months after the due date as follows:

Tax as redetermined by the department	\$1,100.00
Penalty	110.00 (5% failure to file penalty and 5% failure to timely pay penalty)
Interest	15.40 (2 months interest)
Less payment	(\$1,000.00)
Subtotal	\$225.40
Interest	1.58 (1 month interest)
Less payment	(\$114.80)
Remaining tax due	\$112.18
Interest	18.06 (23 months interest)
Total due	\$ 130.24

Example (b) — Timely Filed No Remit

- a. Tax due is \$1,000.
- b. Return timely filed.
- c. \$0 paid.
- d. Assume 0.7% monthly interest for purpose of example.

The calculation for the total amount due five months after the due date is shown below:

Tax	\$1,000.00
Penalty	50.00 (5% failure to timely pay penalty)
Interest	35.00 (5 months interest)
Total due	\$1,085.00

The department bills the amount due in the fifth month after the due date and the taxpayer pays the billed amount in the eighth month after the due date. The payment is applied as follows:

Tax	\$1,000.00

Penalty	50.00 (5% failure to timely pay penalty)
Interest	<u>56.00 (8 months interest)</u>
Subtotal	\$1,106.00
Less payment	<u>(\$1,085.00)</u>
Remaining tax due	\$ 21.00

Taxpayer does not pay the remaining tax due of \$21, which continues to accrue interest. Three years after the due date the taxpayer reports the result of an Internal Revenue Service audit which increases the taxpayer's income and tax due to the department. The department recomputes the taxpayer's liability as follows:

Tax as redetermined by the department	\$1,200.00
Penalty	60.00 (5% failure to timely pay penalty)
Interest	67.20 (8 months interest)
Less payment	<u>(\$1,085.00)</u>
Remaining tax due	\$ 242.20
Interest	<u>47.47 (28 months interest)</u>
Total due	\$289.67

11.8(2) Refunds from department audit. In those instances where a department audit reduced the amount of tax, fees, penalty, and interest due over the amount paid, the department will, when possible, reapply payments so that the amount refunded is tax on which interest will accrue as set forth in the Iowa Code.

11.8(3) Partial payments.

a. Where partial payments are made, the department will apply payments to fees, penalty, interest, and then to tax due. If fees, penalty, interest, and tax are due and owing for more than one tax period, any payment must be applied first to the fees, penalty, then the interest, then the tax for the earliest period, then to the fees, penalty, interest, and tax for each following tax period in chronological order from the earliest tax period to the latest tax period, until the payment is exhausted.

b. Where there are both agreed-to and unagreed-to items as a result of an audit, the taxpayer and the department may agree to apply payments to the fees, penalty, interest, and then to tax due on the agreed-to items of the audit when all of the fees, penalty, interest, and tax on the agreed-to items are paid. In these instances, subsequent payments will not be applied to fees, penalty, and interest accrued on the agreed-to items of the audit.

11.8(4) Taxpayer designation of tax type and period to which voluntary payments are to be applied.

a. A taxpayer may designate in a separate written instruction at the time a voluntary payment is made the type of tax and tax periods to which any voluntary payment is to be applied.

b. The taxpayer may not designate the application of a voluntary payment between fees, penalty, interest, and tax due for a particular type of tax or tax period.

c. The taxpayer may not designate the application of payments which are the result of a jeopardy assessment or enforced collection. Enforced collection includes, but is not limited to, garnishment of wages or bank accounts, setoff of public payments as defined in Iowa Code section 421.65, and seizure of assets.

This rule is intended to implement Iowa Code sections 421.60 and 422.25.

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◇ Two or more ARCs

CHAPTER 19
SETTLEMENTS—COMPROMISES AND ABATEMENTS OF TAX, PENALTY, OR INTEREST

Chapter rescission date pursuant to Iowa Code section 17A.7: 1/17/29

701—19.1(421) Settlements. Pursuant to Iowa Code section 421.5, in addition to the authority granted to the department pursuant to Iowa Code section 17A.10 and notwithstanding Iowa Code section 7D.9, the department may, in its sole discretion, settle any taxes, penalties, or interest. A settlement may be a compromise or full abatement of any amount in dispute.

[ARC 7192C, IAB 12/13/23, effective 1/17/24]

701—19.2(421) Amounts qualifying for settlement. To be eligible for settlement under Iowa Code section 421.5, the amount must be of doubtful liability or doubtful collectability or must cause severe economic hardship, or the settlement of the amount must promote effective tax administration. The decision whether to accept a settlement amount will be based on a taxpayer's facts and circumstances; verifiable documentation is required for all grounds.

19.2(1) *Doubtful collectability.* Doubt as to collectability may exist in any case where the taxpayer's assets and discretionary income may not satisfy the full amount of the liability after satisfying senior priority liabilities. An offer to settle based on doubt as to collectability may be considered acceptable if it is unlikely that the tax, penalty, and interest can be collected in full and the offer reasonably reflects the amount the department could collect through other means, including administrative and judicial collection remedies. This amount is the reasonable collection potential of a case. In determining the reasonable collection potential of a case, the department will take into account the taxpayer's verifiable reasonable basic living expenses. In some cases, the department may accept an offer of less than the reasonable collection potential of a case if there are special circumstances.

19.2(2) *Severe economic hardship.* The department may settle where it determines that, although collection in full could be achieved, collection of the full amount would cause the taxpayer severe economic hardship. Severe economic hardship is defined as the inability to pay reasonable basic living expenses. An offer to settle based on economic hardship may be considered acceptable when, even though the tax, penalty, and interest could be collected in full, the amount offered reflects the amount the department can collect without causing the taxpayer severe economic hardship.

19.2(3) *Doubtful liability.* A doubtful liability may exist where there is a significant doubt as to the existence or amount of the correct tax liability under the law. A doubtful liability does not exist where the liability has been established by a final court judgment or administrative ruling or final order of the department concerning the existence or amount of the liability. An offer to settle a doubtful liability may be considered acceptable if it reasonably reflects the likelihood the department could expect to collect through litigation. This analysis may include consideration of the hazards and costs of litigation that would be involved if the liability were litigated. The evaluation of the hazards and costs of litigation is not an exact science and is within the discretion of the department.

19.2(4) *Promote effective tax administration.* The department may settle to promote effective tax administration where compelling public policy or equity considerations identified by the taxpayer provide a sufficient basis for settling the liability that is equitable under the particular facts and circumstances of the case. Settlements pursuant to this subrule may be justified only where, due to exceptional circumstances, collection of the full liability may undermine public confidence that the tax laws are being administered in a fair and equitable manner. The taxpayer will be expected to demonstrate circumstances that justify settlement even though a similarly situated taxpayer may have paid the liability in full. The department may settle cases where doing so will promote voluntary compliance with the law. The department may decline a settlement for reasons promoting effective tax administration if the settlement of the liability would undermine compliance by taxpayers with the tax laws.

[ARC 7192C, IAB 12/13/23, effective 1/17/24]

701—19.3(421) Settlement procedures and limitations, generally.

19.3(1) *Whether to seek a settlement.* When determining whether to seek a settlement, a taxpayer should first consider whether a settlement is necessary. Nothing in this chapter is intended to preclude a taxpayer who misses the time provided by law to appeal a notice of assessment from paying the amount due, filing a refund claim, and contesting any denial of that refund claim as described in Iowa Code section 421.60(2)“h.” If a taxpayer has not received a billing but has information that would adjust the liability down, the appropriate remedy is to file an amended return within the statute of limitations. If a taxpayer has received an estimated assessment and is within three years of when the assessment was issued, the taxpayer should file a return. If a taxpayer has received an assessment and is within the time period to file an appeal, it is proper to file an appeal rather than a settlement request. If a taxpayer does not dispute the liability, but is unable to pay the liability due to financial hardship, the taxpayer should submit an offer in compromise application.

19.3(2) *Which type of settlement to seek.* Different types of settlements require different forms and procedures. Procedures for abatement, offer in compromise, and voluntary disclosure agreements are described in specific rules below. For matters currently under appeal pursuant to 701—Chapter 7, settlement requests must be submitted to the enforcement actions and appeals bureau of the legal services division in accordance with 701—subrule 7.10(5). For matters currently under audit, settlement requests must be submitted to the department employee assigned to the audit.

19.3(3) *Who may authorize a department settlement.* Only the director, the deputy director, or the division administrator of the legal services division may approve and sign settlements under this chapter unless otherwise specified in rule or designated by the director.

19.3(4) *Discretionary nature of settlements.* There is no right to appeal an abatement denial, offer in compromise denial, or other settlement decision by the department under 701—Chapter 7. As described in Iowa Code section 421.5, a taxpayer shall not have the right to a settlement of any tax, penalty, or interest liability under this chapter or Iowa Code section 421.5. Any determination shall be discretionary and shall be final and conclusive except in the case of fraud or mutual mistake of material fact or as otherwise stated in a written settlement agreement between the taxpayer and the department.

[ARC 7192C, IAB 12/13/23, effective 1/17/24; ARC 0321D, IAB 5/27/26, effective 7/1/26]

701—19.4(421) Applications for abatement.

19.4(1) *When to file.* Abatement is intended to be a possible remedy for taxpayers who have received a billing or refund denial letter and have information that could lead to a reduction in the liability, but failed to file a timely appeal. Grounds for abatement include doubt as to liability and promoting effective tax administration.

19.4(2) *How to file an application.* To apply, a taxpayer must submit an application for abatement in the department’s prescribed paper or electronic format. The application can be submitted through GovConnectIowa or by using the form available on the department’s website and following the submission instructions on the form.

19.4(3) *Required information.* A request for abatement must be submitted on the department’s form. The form must be fully completed and properly signed.

19.4(4) *Review of requests.*

- a. After the application has been submitted, it will be reviewed by department staff.
- b. Additional information may be requested to assist the department in its review.
- c. A letter will be issued to the applicant notifying the applicant of the decision to grant, deny or partially grant the abatement request. The department’s decision on an abatement application will only be contained in a formal determination letter.
- d. Applicants whose applications are granted in part will receive an agreement describing the terms of the partially granted abatement request and must sign and return that agreement to the department in order to receive the partially granted abatement.

e. Decisions to accept an abatement request in full or in part for doubt as to liability may be approved by the bureau chief of the compliance division or another staff member designated by the director.

f. Decisions to accept an abatement request to promote effective tax administration may only be approved by the director, the deputy director, or the division administrator of the legal services division.

19.4(5) *Limitations.* The department will accept applications for abatement during the appeal period but will not review such applications until the appeal period has passed. The department will generally not refund amounts already paid in response to an application for abatement. Some exceptions may include the following circumstances:

a. The application is received within three years after the return related to the application for abatement was due or within one year after the payment related to the application for abatement was made, whichever is later.

b. The application is received within one year of the final determination date of any final federal adjustment arising from an internal revenue service audit or other similar action by the internal revenue service with respect to the particular tax year at issue in the application.

c. Payments were received in violation of Title 11 of the United States Code.

d. Exceptional circumstances demonstrate that a refund would promote effective tax administration as described in subrule 19.2(4).

[ARC 7192C, IAB 12/13/23, effective 1/17/24; Editorial change: IAC Supplement 4/17/24; ARC 0321D, IAB 5/27/26, effective 7/1/26]

701—19.5(421) Offers in compromise.

19.5(1) *When to file.* An offer in compromise packet should be used to apply for relief based on doubtful collectability or severe economic hardship.

19.5(2) *How to submit a packet.* To apply, a taxpayer must submit an offer in compromise packet in the department's prescribed paper or electronic format. An offer in compromise packet can be submitted through GovConnectIowa or by using the form available on the department's website and following the submission instructions on the form.

19.5(3) *Required information.* An offer in compromise must be submitted using the department's offer in compromise packet.

19.5(4) *Review of requests.*

a. After the packet has been submitted, it will be reviewed by department staff.

b. Additional information may be requested to assist the department in its review.

c. A letter will be issued to the applicant notifying the applicant of the decision to grant, deny or partially grant the offer in compromise request. The department's decision on an offer in compromise request will only be contained in a formal determination letter.

d. Applicants whose applications are granted in part will receive an agreement describing the terms of the partially granted offer in compromise request and must sign and return that agreement to the department in order to receive the partially granted offer in compromise.

e. Decisions to enter into an offer in compromise must be approved by the bureau chief of the central collections unit, the director, the deputy director, the division administrator of the legal services division, or another staff member designated by the director.

19.5(5) *Limitations.* The department will not review offer in compromise applications until a liability is at least one year old. Premature applications will be denied. Denial on this basis does not prevent the taxpayer from reapplying at a later date.

[ARC 7192C, IAB 12/13/23, effective 1/17/24; ARC 0321D, IAB 5/27/26, effective 7/1/26]

701—19.6(421) Voluntary disclosure agreements.

19.6(1) *When to file.* Any person who is subject to Iowa tax or tax collection responsibilities may be eligible for the voluntary disclosure program. Being subject to Iowa tax may occur when a person has Iowa source income, business activities, or representatives or other presence in Iowa. Certain

activities by such persons may create Iowa tax return filing requirements for Iowa source income. In addition, activities may also result in tax liabilities that are past due and owing.

19.6(2) Purpose of the voluntary disclosure program. The purpose of the voluntary disclosure program is to promote effective tax administration through voluntary compliance by encouraging unregistered business entities and persons to voluntarily contact the department regarding unreported Iowa source income or other Iowa taxes described in subrule 19.6(4).

19.6(3) Anonymity. A person or the person's representative may initially contact the department on an anonymous basis. Anonymity of the taxpayer can be maintained until the voluntary disclosure agreement is executed by the taxpayer and the department. The voluntary disclosure program may be used by the department and the taxpayer to report previous periods of Iowa source income and to settle outstanding tax, penalty and interest liabilities, but it must also ensure future tax compliance by the taxpayer.

19.6(4) Type of taxes eligible. Only taxes, penalties, and interest related to the following tax types are eligible for settlement under the voluntary disclosure program: corporate income tax, franchise tax, fiduciary income tax, withholding income tax, individual income tax, composite return tax, local option school district income surtax, state sales tax, state use tax, fuel taxes, cigarette and tobacco taxes, local option tax, state and local hotel and motel taxes, automobile rental excise tax, equipment excise tax, water service excise tax, and the prepaid wireless 911 surcharge.

19.6(5) Eligibility of the taxpayer. The department has discretion to determine who is eligible for participation in the voluntary disclosure program. In making the determination, the department may consider the following factors:

- a. The person must be subject to Iowa tax on Iowa source income or have Iowa tax collection responsibilities;
- b. The person must have tax due;
- c. The person must not currently be under audit or examination by the department or under criminal investigation by the department;
- d. The person must not have had any prior contact with the department or a representative of the department that could lead to audit or assessment associated with the tax types or tax periods sought to be addressed under the program;
- e. The type and extent of activities resulting in Iowa source income;
- f. Failure to report the Iowa source income or pay any liability was not due to fraud, intentional misrepresentation, an intent to evade tax, or willful disregard of Iowa tax laws; and
- g. Any other factors which are relevant to the particular situation.

19.6(6) How to file an application.

a. *Required format.* To apply, a taxpayer must submit an application in the department's prescribed paper or electronic format. A voluntary disclosure application can be submitted through GovConnectIowa or by using the form available on the department's website and following the submission instructions on the form.

b. *Required information.* A voluntary disclosure application must be submitted using the department's form.

c. *Review of the application.*

- (1) After the application is submitted, it will be reviewed by department staff.
- (2) Additional information may be requested to assist the department in its review.
- (3) The department will notify an applicant in writing regarding whether the applicant's application for participation in the program is accepted or rejected.

19.6(7) Terms of the voluntary disclosure agreement.

a. *Discretion.* The department has the discretion to settle any outstanding Iowa tax, penalty, and interest liabilities of the eligible applicant. Settlement terms are on a case-by-case basis. Items considered by the department in determining the settlement terms include: the type of tax, the tax periods at issue, the reason for noncompliance, whether the tax is deemed to be held in trust for the

state of Iowa, the types of activities resulting in the tax, the frequency of the activities that resulted in the tax, and any other matters which are relevant to the particular situation.

b. Maximum scope of audit. If a taxpayer initiates the contact with the department and is eligible for the voluntary disclosure program and complies with the agreement terms, the maximum prior years for which the department will generally audit and pursue settlement and collection will be five years, absent an intent to defraud, the making of material misrepresentations of fact, or an intent to evade tax.

c. Future filing requirements. All voluntary disclosure agreements must require that the applicant file future Iowa tax returns, unless the activity by the applicant resulting in the Iowa source income has changed or there has been a change in the law, rules, or court cases that dictate a different result.

d. Audit and assessment rights. The department reserves the right to audit all returns and other documents submitted by the applicant or a third party to verify the facts and whether the terms of the voluntary disclosure agreement have been met. The department may audit information submitted by the applicant at any time within the allowed statutory limitation period. The department may also assess any tax, penalty, and interest found to be due in addition to the amount of original tax reported. The statute of limitations for assessment and statute of limitations for refunds begin to run as provided by law.

19.6(8) Commencement of the voluntary disclosure agreement. The voluntary agreement commences on the date the voluntary disclosure agreement is fully executed by all parties or another date specified by the agreement. Execution of the agreement is complete when the agreement is executed by the taxpayer or taxpayers and the division administrator or a bureau chief within the compliance division or another staff member designated by the director. Prior to the execution of the voluntary disclosure agreement by the taxpayer and the department, the taxpayer is not protected from the department's regular audit process if the identity of the taxpayer, as an applicant, is unknown to the department. However, if the department has knowledge of the taxpayer's identity, as an applicant, the department will not take audit action against the taxpayer during the voluntary disclosure process. If a voluntary disclosure agreement is not reached, the department may assess tax, penalty, and interest as provided by law at the time the identity of the applicant becomes known to the department.

19.6(9) Voiding a voluntary disclosure agreement.

a. Authority. The department has the authority to declare a voluntary disclosure agreement null and void subsequent to the execution of the agreement. The department may void the contractual agreement if the department determines that a misrepresentation of a material fact was made by the person or a third party representing the person to the department. The department may also void a voluntary disclosure agreement if the department determines any of the following has occurred:

(1) The person does not submit information requested by the department within the time period specified by the department, including any extensions granted by the department;

(2) The person fails to file future Iowa returns as agreed to in the voluntary disclosure agreement;

(3) The person does not pay the agreed settlement liability within the time period designated by the department, including any extensions of time that may be granted by the department;

(4) The person does not remit all taxes imposed upon or collected by the person for all subsequent tax periods and all tax types that are subject to the voluntary disclosure agreement;

(5) The person fails to prospectively comply with Iowa tax law. Whether the person has failed to prospectively comply with Iowa tax law is determined by the department on a case-by-case basis;

(6) The person, based on a determination by the department, materially understates the person's tax liability; or

(7) The person has made a material breach of the terms of the voluntary disclosure agreement.

b. Audit rights. Voiding of the agreement results in nonenforceability of the agreement by the applicant and allows the department to proceed to assess tax, penalty, and interest for that person's Iowa tax and tax collection responsibilities for all periods within the statute of limitations. If the applicant is justifiably rejected for the voluntary disclosure program or the agreement between the

person and the department is declared by the department to be null and void, the department reserves the right to audit all returns or other documents submitted by the applicant or a third party on behalf of the applicant and to make an assessment for all tax, penalty, and interest owed. If the voluntary disclosure agreement is voided or the application for the program is rejected and the department issues an assessment, the taxpayer may appeal the assessment pursuant to 701—Chapter 7. If the department does not issue an assessment, but does reject the application or voids the agreement, such action is not subject to appeal under 701—Chapter 7 but is considered to be “other agency action.”

19.6(10) *Partnerships, partners, S corporations, shareholders in S corporations, trusts, and trust beneficiaries.* Once the department has initiated an audit or investigation of any type of partnership, partners of the partnership, S corporations, a shareholder in an S corporation, a trust, or trust beneficiaries, the department is deemed to have initiated an audit or investigation of the entity and of all those who receive Iowa source income from or have an interest in such an entity for purposes of eligibility for participation in the voluntary disclosure program.

19.6(11) *Transfer or assignment.* The terms of the voluntary disclosure agreement are valid and enforceable by and against all parties, including their transferees and assignees.

[ARC 7192C, IAB 12/13/23, effective 1/17/24; ARC 0321D, IAB 5/27/26, effective 7/1/26]

These rules are intended to implement Iowa Code sections 421.5 and 421.17.

[Filed ARC 7192C (Notice ARC 7101C, IAB 10/18/23), IAB 12/13/23, effective 1/17/24]

[Editorial change: IAC Supplement 4/17/24]

[Filed ARC 0321D (Notice ARC 0174D, IAB 4/1/26), IAB 5/27/26, effective 7/1/26]

CHAPTER 10 DISCIPLINE

[Prior to 2/8/89, see Veterinary Medicine, Board of[842] Ch 6]

Chapter rescission date pursuant to Iowa Code section 17A.7: 7/1/29

811—10.1(17A,169,272C) Board authority. The board may discipline any credential holder for any grounds stated in Iowa Code chapters 169 and 272C or rules promulgated thereunder.

[ARC 8019C, IAB 5/15/24, effective 7/1/24]

811—10.2(17A,169,272C) Complaints and investigations.

10.2(1) Complaints are allegations of wrongful acts or omissions relating to the ethical or professional conduct of a credential holder.

10.2(2) The executive secretary or authorized designee investigates complaints in order to determine the probability that a violation of law or rule has occurred.

[ARC 8019C, IAB 5/15/24, effective 7/1/24]

811—10.3(17A,169,272C) Investigatory subpoena powers. The board has the authority to issue an investigatory subpoena in accordance with the provisions of Iowa Code section 17A.13.

10.3(1) A subpoena which requires production of real evidence that is necessary to an investigation may be issued upon the authority of the executive secretary or a designee.

10.3(2) Any person who is aggrieved or adversely affected by compliance with the subpoena and who desires to challenge the subpoena has 14 days after the service of the subpoena, or before the time specified for compliance if such time is less than 14 days, to file with the board a motion to quash or modify the subpoena. The motion will describe legal reasons why the subpoena should be quashed or modified and may be accompanied by legal briefs or factual affidavits.

10.3(3) Iowa Code section 272C.6(3) “a”(3) contains information regarding what happens in the event obedience to a subpoena is refused.

[ARC 8019C, IAB 5/15/24, effective 7/1/24]

811—10.4(17A,169,272C) Board action. The board will review investigative conclusions and take one of the following actions:

1. Close the investigative case without action.
2. Request further inquiry.
3. Appoint a peer review committee to assist with the investigation.
4. Determine the existence of sufficient probable cause and order a disciplinary hearing to be held in compliance with Iowa Code section 272C.6.

[ARC 8019C, IAB 5/15/24, effective 7/1/24]

811—10.5(17A,169,272C) Peer review committee. The board may establish a peer review committee to assist with the investigative process when deemed necessary.

10.5(1) The committee will determine if the conduct of the credential holder conforms to minimum standards of acceptable and prevailing practice of veterinary medicine or other applicable standards and submit a report of its findings to the board.

10.5(2) The board will review the committee’s findings and proceed with action available under rule 811—10.4(17A,169,272C).

10.5(3) The confidentiality requirements imposed by Iowa Code section 272C.6 apply to the peer review committee.

[ARC 8019C, IAB 5/15/24, effective 7/1/24]

811—10.6(17A,169,272C) Grounds for discipline and principles of veterinary medical ethics. The provisions of Iowa Code sections 272C.10 and 169.13 are incorporated by reference. The board has established grounds for discipline and principles of ethics for veterinary medicine. Without regard

as to whether the board has determined that an injury has occurred, the board may impose any of the disciplinary sanctions set forth in rule 811—10.7(17A,169,272C), including civil penalties in an amount not to exceed \$10,000, when the board determines that the credential holder is guilty of any of the following acts or offenses:

10.6(1) *Grounds applicable to all credential holders.*

a. Fraud in procuring a credential, which includes but is not limited to an intentional perversion of the truth in making application for a credential to practice any of the professions or activities regulated by the board in this state and includes false representations of a material fact, whether by word or by conduct, by false or misleading allegations, or by concealment of that which should have been disclosed when making application for a credential in this state, or attempting to file or filing with the board or the Iowa department of agriculture and land stewardship any false or forged diploma, certificate, affidavit, identification, or qualification in making an application for a credential in this state.

b. Professional incompetency of a credential holder may be established by:

(1) A substantial lack of knowledge or ability to discharge professional obligations within the scope of the credential holder's practice.

(2) A substantial deviation by the credential holder from the standards of learning or skill ordinarily possessed and applied by other credential holders acting in the same or similar circumstances.

(3) A willful or repeated departure from or the failure to conform to the minimal standards of acceptable and prevailing practice of credential holders.

(4) Knowingly making misleading, deceptive, untrue or fraudulent representations in the practice of the profession or engaging in unethical conduct or practice harmful or detrimental to the public.

1. Knowingly making misleading, deceptive, untrue or fraudulent representations in the practice of the profession includes, but is not limited to, an intentional perversion of the truth, either orally or in writing, and includes any representation contrary to legal or equitable duty, trust or confidence and is deemed by the board to be contrary to good conscience, prejudicial to the public welfare or may operate to the injury of another.

2. Practice harmful or detrimental to the public includes, but is not limited to, the failure of a credential holder to possess and exercise that degree of skill, learning and care expected of a reasonable, prudent credential holder acting in the same or similar circumstances, including for a veterinarian a violation of the standards of practice as set out in 811—Chapter 12, or when a credential holder is unable to practice with reasonable skill and safety on a client's animals as a result of a mental or physical impairment or chemical abuse.

c. Habitual intoxication or addiction to the use of drugs means the same as Iowa Code section 169.13(1) "*h.*" The board may mandate a credential holder's completion of a treatment program as a condition of probation or suspension and will consider the credential holder's willingness to complete a treatment program when determining the appropriate degree of disciplinary sanction.

d. Conviction of a felony or misdemeanor, which includes, but is not limited to, the conviction of a public offense in the practice of the credential holder's profession and is defined or classified as a felony under state or federal law, or violation of a statute or law designated as a felony in this state, another state, or the United States, which statute or law directly relates to the credential holder's profession or ability to practice within the profession.

e. Fraud in representations as to skill or ability, which includes but is not limited to a credential holder's having made misleading, deceptive or untrue representations as to the credential holder's competency to perform professional services for which the credential holder is not qualified to perform by training or experience.

f. Use of untruthful or improbable statements in advertisements, which includes but is not limited to an action by a credential holder in making information or intention known to the public which is false, deceptive, misleading or promoted through fraud or misrepresentation and includes statements which may consist of, but not be limited to:

- (1) Inflated or unjustified expectations of favorable results;
 - (2) Self-laudatory claims that imply that the credential holder engaged in a field or specialty of practice for which the credential holder is not qualified. A veterinarian is not qualified to claim or imply specialization unless the veterinarian is a member in good standing of the respective specialty board or college recognized by the AVMA;
 - (3) Representations that are likely to cause the average person to misunderstand; or
 - (4) Extravagant claims or claims of extraordinary skills not recognized by the credential holder's profession.
- g. Willful or repeated violations of the provisions of Iowa Code chapters 169 and 272C and rules promulgated thereunder by the board.
 - h. Failure to report a license, certificate, permit, or other credential revocation, suspension or other disciplinary action taken by a licensing or regulating authority of another state, territory or country within 30 days of the final action by such licensing or regulating authority. A stay by an appellate court cannot negate this requirement; however, if such disciplinary action is overturned or reversed by a court of last resort, such report is expunged from the records of the board.
 - i. Failure of a credential holder or an applicant for a credential in this state to report, within 30 days, any settlement agreement or voluntary agreement to limit the practice of veterinary medicine or other applicable activities entered into in another state, district, territory or country or those included in Iowa Code section 272C.9 or 169.13.
 - j. Knowingly submitting a false report of continuing education or failure to submit the triennial report of continuing education.
 - k. Failure to comply with a subpoena issued by the board.
 - l. Willful or gross negligence.
 - m. Obtaining any fee by fraud or misrepresentation.
 - n. Violating any of the grounds for the revocation or suspension of a credential as listed in Iowa Code section 169.13 or these rules.
 - o. A violation of Iowa Code section 169.13(1)“d”; having the person's certificate, license, permit, or other credential revoked or suspended by the United States Department of Agriculture (USDA); or having the veterinarian's USDA accreditation revoked, suspended or other disciplinary action taken against the accreditation.
 - p. Failing to comply with a lawful child support order as provided in 811—Chapter 13.
 - q. Failing to pay any hearing fees and costs within the time specified in the board's decision.
 - r. Failure to satisfy the continuing education requirements of rule 811—8.10(169,272C).

The board cannot suspend or revoke a license issued by the board to a person who is in circumstances outlined by Iowa Code section 272C.4(10).

10.6(2) Grounds applicable to licensed veterinarians only. In addition to the grounds set out in subrule 10.6(1), without regard as to whether the board has determined that injury has occurred, a licensed veterinarian is subject to disciplinary action for the violation of any of the following:

- a. Engaging in unethical conduct which includes, but is not limited to, a violation of the standards of practice as set out in 811—Chapter 12, and which may include acts or offenses in violation of Iowa’s principles of veterinary medical ethics, as adopted in subrule 10.6(3).

b. Engaging in practice harmful or detrimental to the public which includes, but is not limited to, either of the following:

- (1) The use of a rubber stamp to affix a signature to a prescription. A licensee who is unable, due to a physical disability, to make a written signature or mark may substitute in lieu of a signature a rubber stamp which is adopted by the disabled person for all purposes requiring a signature and which is affixed by the disabled person or affixed by another person upon the request of the disabled person and in the licensee's presence.

- (2) The practice of maintaining any presigned prescription which is intended to be completed and issued at a later time.

- c. Iowa Code section 169.13(1) “g.”

d. Indiscriminately or promiscuously prescribing, administering or dispensing any drug; or prescribing, administering or dispensing any drug for other than a lawful purpose.

e. Permitting or directing any veterinary auxiliary personnel or any other person who does not hold the proper credentials to perform veterinary duties involving diagnosis, prescription or surgery, except as allowed pursuant to subrule 8.7(4).

f. Permitting or directing any veterinary auxiliary personnel or any other person to perform any act that would be a legal or ethical violation if committed by a veterinarian.

g. Negligently failing to exercise due care in the delegation of veterinary services to or in supervision of veterinary auxiliary personnel, whether or not injury results.

10.6(3) *Principles of veterinary medical ethics.* All Iowa-licensed veterinarians are expected to adhere to these principles of veterinary medical ethics listed below and adopted by the board.

a. General ethics principles.

(1) A veterinarian may only be influenced by the welfare of the patient, the needs of the client, the safety of the public, and the need to uphold the public trust vested in the veterinary profession and shall avoid conflicts of interest or the appearance thereof.

(2) A veterinarian shall provide competent veterinary medical care under the terms of a veterinarian-client-patient relationship (VCPR), with compassion and respect for animal welfare and human health.

(3) A veterinarian shall uphold the standards of professionalism, be honest in all professional interactions, and report veterinarians who are deficient in character or competence to the appropriate entities.

(4) A veterinarian shall not willfully violate the provisions of Iowa Code chapters 169 and 272C and rules promulgated thereunder by the board, or other law of this state, another state, or the United States, which relates to the practice of veterinary medicine.

(5) A veterinarian shall respect the rights of clients, colleagues, and other health professionals and safeguard medical information within the confines of the law.

(6) A veterinarian shall continue to study, apply, and advance scientific knowledge; maintain a commitment to veterinary medical education; make relevant information available to clients, colleagues, and the public; and obtain consultation or referral when indicated.

(7) A veterinarian shall, in the provision of appropriate patient care, be free to choose whom to serve, with whom to associate, and the environment in which to provide veterinary medical care.

(8) A veterinarian shall not advertise a specialty or claim to be a specialist when not a diplomate of a veterinary specialty organization recognized by the AVMA.

b. Veterinarian-client-patient relationship ethics. A veterinarian shall not engage in the practice of veterinary medicine without a valid VCPR as defined in these rules.

c. Veterinarian-client communication; documentation of informed consent.

(1) A veterinarian shall explain to clients how any diagnostic tests offered would help diagnose a patient's medical condition.

(2) A veterinarian is responsible for professional communication directly with the client regarding diagnosis, options for treatment(s), expected cost of treatment(s), expected outcome of treatment(s), and the potential risks associated with each treatment regimen, as well as the client's ability to decline treatment(s). Client consent for the treatment(s) shall be documented in the patient's medical records. Veterinary auxiliary personnel may communicate the information listed in this subparagraph to the client under the supervision of an Iowa-licensed veterinarian.

(3) If a veterinarian does not have the expertise or the necessary equipment and facilities to adequately diagnose or treat a patient, the veterinarian shall offer a referral to another veterinarian where the diagnosis or treatment can be performed.

d. Veterinary medical records.

(1) Complete, accurate and legible medical records that are considered to meet the prevailing standard of the practice of veterinary medicine are set by the board.

(2) Any controlled substances administered to a patient must be written into the patient's medical record, which shall include the drug name, the date the drug was administered, the amount of drug administered, the frequency of drug administration, and the prescribing (and administering, if different) veterinarian's name, pursuant to rules 811—12.2(169) to 811—12.4(169). This requirement is in addition to regulations and requirements promulgated by the Iowa board of pharmacy, U.S. Drug Enforcement Administration, and any other applicable governmental agency. Violating or failing to comply with a state or federal law or regulation relating to the storing, labeling, prescribing, or dispensing of controlled substances is unethical.

(3) Humane euthanasia of animals is an ethical veterinary procedure. A veterinarian can refuse to perform euthanasia.

e. Client and patient privacy rights.

(1) A veterinarian shall protect and respect the privacy rights of clients, colleagues, and other health professionals. A veterinarian shall not reveal confidential medical records or other medical information unless authorized to do so by law.

(2) It is unethical to place photographs or information regarding a patient, a client, or a client's premises on social media or other public platforms without the consent of the owner, unless the patient, client, or client's premises cannot be identified by its marking and unless all personally identifying information has been removed from the photograph. Use of photographs and information for didactic purposes is permitted with client consent or after removal of any information that would identify the client or patient.

f. Professional behavior.

(1) A veterinarian shall be honest in all professional interactions while respecting the rights of clients, colleagues, and other health professionals. A veterinarian must be honest and fair in relations with others, and a veterinarian shall not engage in fraud, misrepresentation, or deceit, including by material omission, in accordance with Iowa Code section 169.13(1) "a."

(2) A veterinarian must not defame or injure the professional standing or reputation of another veterinarian in a false or misleading manner. Any complaints about behavior of a veterinarian that may violate the principles of veterinary medical ethics should be addressed through the board in an appropriate and timely manner.

(3) A veterinarian who is impaired due to substance abuse or mental health or physical conditions as set forth in Iowa Code section 169.13(1) "h" must not act in the capacity of a veterinarian and shall seek medical treatment from qualified organizations or individuals.

10.6(4) *Recommended practices for veterinarians.*

a. A veterinarian is encouraged to participate in activities contributing to the improvement of the community and the betterment of public health. The responsibilities of the veterinary profession extend beyond individual patients and clients to society in general.

b. A veterinarian is encouraged to participate in the political process to seek changes to laws and regulations that are contrary to the best interests of the patient, the client and public health.

c. A veterinarian is encouraged to make the veterinarian's knowledge available to the community and to provide the veterinarian's services for activities that protect public health.

d. A veterinarian is encouraged to view, evaluate, and treat all individual persons in any professional activity or circumstance in which the veterinarian may be involved solely as individuals on the basis of the person's personal abilities, qualifications and character.

[ARC 8019C, IAB 5/15/24, effective 7/1/24; ARC 0322D, IAB 5/27/26, effective 7/1/26]

811—10.7(17A,169,272C) Sanctions. The board has the authority to impose disciplinary sanctions in circumstances allowed by Iowa Code section 272C.3(2) "a" through "f."

[ARC 8019C, IAB 5/15/24, effective 7/1/24]

811—10.8(17A,169,272C) Panel of specialists. The board may appoint a panel of veterinarians who are specialists to ascertain the facts of a case pursuant to Iowa Code section 272C.6(2). The board chairperson or designee appoints the presiding officer.

10.8(1) The executive secretary sets the date, time, and location of the hearing and makes proper notification to all parties.

10.8(2) The panel of specialists shall:

a. Enter into the record the names of the presiding officer, members of the panel, the parties and their representatives.

b. Enter into the record the notice and evidence of service, order for hearing, statement of charges, answer, if available, and any other pleadings, motions or orders.

c. Receive opening statements from the parties.

d. Receive evidence, in accordance with Iowa Code section 17A.14, on behalf of the state of Iowa and on behalf of the credential holder.

e. Question the witnesses.

f. Receive closing statements from the parties.

g. Determine the findings of fact by a majority vote and make a written report of its findings to the board within a reasonable period.

[ARC 8019C, IAB 5/15/24, effective 7/1/24]

811—10.9(17A,169,272C) Informal settlement. Pursuant to the provisions of Iowa Code sections 17A.12 and 272C.3, the board may consider resolution of disciplinary matters through informal settlement prior to commencement of contested case proceedings. The secretary or designee may negotiate with the credential holder regarding a proposed disposition of the controversy. Upon consent of both parties, the board will review the proposal for action.

[ARC 8019C, IAB 5/15/24, effective 7/1/24]

811—10.10(17A,169,272C) Voluntary surrender. A voluntary surrender of credentials may be submitted to the board as resolution of a contested case or in lieu of continued compliance with a disciplinary decision of the board.

[ARC 8019C, IAB 5/15/24, effective 7/1/24]

811—10.11(17A,169,272C) Application for reinstatement. A person whose credential has been suspended, revoked, or voluntarily surrendered may apply to the board for reinstatement in accordance with the terms and conditions of the order.

10.11(1) If the credential was voluntarily surrendered, or if the order for suspension or revocation did not establish terms and conditions for reinstatement, an initial application cannot be made until one year has elapsed from the date of the order.

10.11(2) The application alleges facts and circumstances which will enable the board to determine that the basis for the sanction or voluntary surrender no longer exists and that it is in the public interest to reinstate the credential. The burden of proof to establish these facts rests with the petitioner.

10.11(3) The hearing in an application for reinstatement is a contested case within the meaning of Iowa Code section 17A.12.

10.11(4) The order to grant or deny reinstatement incorporates findings of fact and conclusions of law. If reinstatement is granted, terms and conditions for reinstating the credential may be imposed.

[ARC 8019C, IAB 5/15/24, effective 7/1/24]

These rules are intended to implement Iowa Code chapters 17A, 169, and 272C.

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[Filed ARC 0322D (Notice ARC 0124D, IAB 3/18/26), IAB 5/27/26, effective 7/1/26]

WORKFORCE DEVELOPMENT DEPARTMENT[871]

[Prior to 9/24/86, see Employment Security[370], renamed Job Service Division[345]
under the “umbrella” of Department of Employment Services by 1986 Iowa Acts, chapter 1245]
[Prior to 3/12/97, see Job Service Division[345],
renamed Department of Workforce Development by 1996 Iowa Acts, chapter 1186]

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Chapter rescission date pursuant to Iowa Code section 17A.7: 5/4/31

The Uniform Rules on Agency Procedure, 7—Chapters 2500 through 2506, are rules generally applicable to agencies pursuant to Iowa Code section 17A.24. Additions, exceptions, or amendments to the corresponding chapter are below.

[ARC 0299D, IAB 5/27/26, effective 5/4/26]

871—2506.1(17A) Scope and applicability. 7—Chapter 2506 applies to contested case proceedings conducted by the agency, including vendor appeals. However, 7—Chapter 2506 does not apply to the extent that a contested case being addressed by the agency is governed by 20 CFR Part 683, Subpart F, as amended to May 4, 2026; 29 CFR Parts 29 and 30 as amended to May 4, 2026; 34 CFR Part 361 as amended to May 4, 2026; or 871—Chapter 26.

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